Hospital Inpatient Quality Reporting (IQR) Program

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

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) Version 5.15a Review & Updates Presentation Transcript

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Donna Bullock: Hello, and welcome to today's presentation: *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) Version 5.15a Review & Updates.* My name is Donna Bullock, and I am with the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator for today's event. Before we begin, I would like to make a few announcements. This program is being recorded. The recording, a transcript of the presentation, along with a question-and-answer summary, will be posted to the Quality Reporting Center website in the upcoming weeks. That website is www.QualityReportingCenter.com.

If you registered for this event, a link to the slides was emailed to you a few hours ago. If you did not receive that email, you can download the slides from the Quality Reporting Center website, or, during the webinar, you can use the link provided in the Handout section.

This webinar has been approved for 1.5 continuing education credits. More information will be provided at the end of the event.

If you have questions before the end of the webinar, please type them into the Ask a Question window along with the associated slide number if possible, and we will answer questions as time allows after the event. If you have questions before the end of the webinar, please type them into the Ask a Question window, along with the associated slide number, if possible, and we will answer questions as time allows after the event.

Today's speakers are Noel Albritton, Lead Solutions Specialist, with the Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor, and Jennifer Witt, Senior Quality Improvement Facilitator, also with the Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor.

The purpose of today's event is to clarify the changes and outline the rationale behind the updates to the Sepsis measure and guidance in Version 5.15a of the specifications manual and respond to frequently asked questions.

At the conclusion of this webinar, participants will be able to understand and interpret the guidance in Version 5.15a, effective for January 1, 2024, through June 30, 2024, discharges, of the specifications manual to ensure successful reporting of the SEP-1 measure.

This slide displays a list of the acronyms and abbreviations that may be used during the presentation.

If we do not answer your question during the webinar, please submit your question to the QualityNet Question and Answer Tool. Noel will provide further information about this process later in the webinar. I would now like to turn the presentation over to Noel.

Noel Albritton: Thanks, Donna. Hello, everyone. Thank you for joining us. Today we will review the guidance for the SEP-1 measure in specifications manual Version 5.15a. We will review guidance that was updated in manual Version 5.15a as well as review guidance that is frequently asked about. Updated guidance to manual Version 5.15a is noted in yellow highlight throughout the presentation and in the specifications manual. You can find the SEP-1 algorithm in the hospital inpatient specifications manual on the QualityNet website at QualityNet.cms.gov.

Let's begin with the *Severe Sepsis Present* data element and the new guidance related to documentation of COVID-19 or coronavirus. The abstraction guidance continues to state: Select Value 2 which means severe sepsis is not present, if there is physician/APN/PA documentation that coronavirus or COVID-19 was present or suspected. Based on questions and scenarios we have received from hospitals and abstractors, two new sub-bullet points were added to the manual in Version 5.15a. The first new sub-bullet point states: Do not use physician/APN/PA documentation that refers to a previous diagnosis of COVID-19 or coronavirus with the examples of "recent COVID-19" or "history of COVID-19." For this guidance, if there was only documentation of a previous diagnosis of COVID-19, you would disregard that documentation because it does not reflect that COVID-19 or coronavirus is currently present or suspected.

Next, let's review the second new sub-bullet point related to this guidance. This updated sub-bullet point is also under the abstraction guidance that states to select Value 2 if there is physician/APN/PA documentation that coronavirus or COVID-19 was present or suspected. This new guidance states: Do not use documentation that COVID-19 is suspected or present if there is physician/APN/PA documentation that coronavirus or COVID-19 is not suspected or present within six hours following the initial documentation that coronavirus or COVID-19 is suspected or present. The new example for this guidance includes an ED MD note at 0700 that states, "Suspect COVID-19 is cause of current respiratory symptoms." An admitting MD note at 1115 states, "Possible pneumonia, COVID-19 test negative." Do not use documentation that COVID-19 is suspected or present because there is subsequent physician documentation within six hours indicating COVID-19 is not present. It's important to notice in this example that the initial documentation of "suspect COVID-19" is not used because the admitting physician documentation within six hours later includes documentation that the COVID-19 test was negative. While there may be documentation from the lab that includes the negative test result, to not use the initial documentation of "suspect COVID-19," there must be physician/APN/PA documentation that COVID-19 was not present. Let's review a few frequently asked questions related to the new abstraction guidance.

This question is often asked due to the location of the physician's documentation of COVID-19. The question is: Would you select Value 2 (No) for the *Severe Sepsis Present* data element based only on the physician documentation of COVID-19 in the Current Problems list? The patient was admitted from February 21 through February 25, 2024. Then, in the MD note, we can see a Current Problems list with the documentation of COVID-19 with the date 9/18/2023. The answer is No. You would not select Value 2 (No) for the *Severe Sepsis Present* data element based only on this documentation because the physician's documentation of COVID-19 includes a previous date for the diagnosis. Even though the heading of the problems list refers to current problems, you would still abstract based on the physician's documentation of COVID-19 with the date from last year.

Since the date for the diagnosis of COVID-19 does not reflect it is a current problem or currently present or suspected, you would not use this documentation to select Value 2 (No) for the *Severe Sepsis Present* data element. Let's look at a similar scenario.

This question is similar to the previous one. However, there are some key differences that cause us to abstract the documentation differently. This question is: Would you select Value 2 (No) for the *Severe Sepsis Present* data element based only on the physician documentation of COVID-19 in the Current Problems list below? In this scenario, we can see the patient was admitted to the hospital from March 2, 2024, through March 9, 2024. The medical record includes a Past Problems list. On the Past Problems list there is physician documentation of COVID-19 with a date of March 4, 2024. The answer to this question is Yes. You would select Value 2 (No) for the *Severe Sepsis Present* data element because the physician documentation of COVID-19 includes the date that reflects COVID-19 is currently present. I do want to point out with this scenario, if COVID-19 was documented on the Past Problems list without a current date, you would not use the documentation to select Value 2 (No) because it would only be referring to a previous diagnosis. Let's take a look at a couple more scenarios we frequently receive related to the updated COVID-19 abstraction guidance.

This question asks: Would you use the documentation below to select Value 2 (No) for the *Severe Sepsis Present* data element based only on the documentation below? There is MD documentation on 2/19 at 0830 that states, "Patient is a 48-year-old female c/o of feeling ill and weak for past three days. Suspect COVID-19 based on presenting s/s. Will add isolation order and order labs." Then, on 2/19 at 0930 there is a lab report that includes the COVID-19 test was negative. The answer is Yes. You would select Value 2 (No) for the *Severe Sepsis Present* data element because there is physician documentation of "suspect COVID-19," and there is no physician/APN/PA documentation within six hours that states COVID-19 was not present or suspected. Next, you can participate in answering the following knowledge check question.

Which allowable value would you select for *Severe Sepsis Present?* The MD stated: No COVID-19 at 1400. Then, the PA stated: COVID-19 possible at 1600. A. Value 1 (Yes) or B. Value 2 (No). We'll give you a few more seconds to select your answer.

Select B, Value 2 (No), for the *Severe Sepsis Present* data element because the PA documentation of "COVID-19 possible" is after the MD documentation indicating COVID-19 was not present. If you recall from the updated guidance, we reviewed earlier to not use the documentation of COVID-19 being suspected or present, there must be physician/APN/PA documentation within six hours after the documentation indicating COVID-19 was suspected or present. Since the documentation of "no COVID-19" in this scenario was not documented within six hours after the PA documentation of "COVID-19 possible," you would select Value 2 (No) for the *Severe Sepsis Present* data element in this example. Let's review one more frequently asked scenario.

This question asks: Would you select Value 2 (No) for the *Severe Sepsis Present* data element based only on the physician documentation below? In the ED MD documentation on 4/22 at 1500 it states, "Patient presenting to the ED from urgent care with positive COVID-19 test and moderate COVID-19 symptoms." Then, on 4/22 at 1800 the hospitalist documented, "The patient was admitted with respiratory symptoms including shortness of breath. Initially thought COVID-19, but that has been ruled out. Likely pneumonia." The answer is No. You would not select Value 2 (No) for the *Severe Sepsis Present* data element based on this documentation because there is physician documentation indicating COVID-19 was not present within six hours after the initial documentation that COVID-19 was present or suspected. Next, we are going to discuss the updates made to the *Severe Sepsis Presentation Date* and *Time* data elements.

A new sub-bullet point was added to the *Severe Sepsis Presentation Date* and *Severe Sepsis Presentation Time* data elements in manual Version 5.15a. The new guidance applies to the primary bullet point and states: "Use the earliest documented arrival date and time for patients who enter the Emergency Department with the following."

Then, the new guidance states: "Physician/APN/PA documentation that severe sepsis was present with a documented presentation date and time that is prior to arrival." In this scenario, if there is physician/APN/PA documentation that severe sepsis was present with a date or time that is before the patient arrived to the hospital, you would use the arrival date and time as the *Severe Sepsis Presentation Date* and *Time*. Let's take a look at a frequently asked question related to this scenario.

This scenario is similar to the questions we received that led to updating the abstraction guidance. This question asks: Which date and time would you use for the *Severe Sepsis Presentation Date* and *Time* based on the information below? There is a physician note that states, "Pt. met severe sepsis criteria on 4/28/2024 at 1600." However, we can see that the arrival date and time to ED was 4/28/2024 at 1830, and the patient was admitted to the ICU on 4/28/2024 at 1945. You would use 4/28/2024 at 1830 as the *Severe Sepsis Presentation Date* and *Time* because the physician's documentation of severe sepsis includes a presentation date and time that is prior to the patient arriving to the ED. Based on the updated guidance we discussed on the previous slide, you would not use 1600 as *Severe Sepsis Presentation Time* because that time was prior to arrival. You would also disregard the time the patient was admitted to the ICU in this case because the new abstraction guidance states to use the arrival time. Let's review one more scenario.

This is another scenario we received questions on related to determining the *Severe Sepsis Presentation Date* and *Time*. This question asks: Which date and time would you use for the *Severe Sepsis Presentation Date* and *Time* based on the information below? There's a physician note that states, "Pt. sent from clinic to rule out severe sepsis." The specific date and time is May 25, 2024, at 1300. Then, we can see the patient's arrival date and time to the ED was May 25, 2024, at 1330, and the patient was admitted on May 25, 2024, at 1830. You would use May 25, 2024, at 1330 as the *Severe Sepsis Presentation Date* and *Time* based on the documentation of ruling out severe sepsis with the prior-to-arrival time stamp.

Again, you would not use the admission date and time in this scenario because severe sepsis was documented with a time that was prior to arrival. Next, we are going to review the updates to the *Directive for Comfort Care or Palliative Care* data element.

The directive for *Directive for Comfort Care or Palliative Care Severe Sepsis and Septic Shock* data elements received updates to address acceptable terms for meeting the data elements. The updated abstraction guidance states, "Only accept terms identified in the list of inclusions or synonymous with an inclusion term." You may recall that previously this abstraction guidance stated, "Do not accept any other terminology." That statement was removed, and the allowance for terms synonymous with an inclusion term was added. This update was made due to scenarios we were receiving from hospitals and abstractor that included terms synonymous with an inclusion term. However, the synonymous terms were not acceptable due to the abstraction guidance stating, "Only accept terms identified in the list of inclusions, and do not accept any other terminology." Let's take a look some scenarios involving synonymous terminology.

This scenario is similar to the questions we received which led to the updated abstraction guidance in manual Version 5.15a. This question asks: Would you select Value 1 (Yes) for the *Directive for Comfort Care or Palliative Care* data element based only on the documentation below? There is a Palliative Medicine Consult ordered on 2/19/2024 at 1800. Then, there is the *Severe Sepsis Presentation Date* and *Time* of 2/19/2024 at 2100. The answer is Yes. You would select Value 1 (Yes) for the *Directive for Comfort Care or Palliative Care Severe Sepsis* data element because the physician ordered a palliative medicine consult, and this terminology is synonymous with the inclusion term "palliative consult." Next, you can participate in the following knowledge check question.

Which allowable value would you select if the *Severe Sepsis Presentation Time* was 1500 and the MD stated, "Plan to consult hospice team at 1700?" A. Value 1 (Yes) or B. Value 2 (No). We'll give you a few more seconds to select your answer.

Select A, Value 1 (Yes), because the physician's documentation reflects the plan to consult hospice, and it is documented within the specified time frame of before or within six hours after the *Severe Sepsis Presentation Time*. Let's take a look at one more example that we often receive questions about.

This question asks: Would you select Value 1 (Yes) for the *Directive for Comfort Care or Palliative Care* data element based only on the documentation below? There is an MD note that states, "Pt. with multiple co-morbidities, family agreeable with comfort focused treatment at this time." Yes, you would select Value 1 (Yes) for the *Directive for Comfort Care or Palliative Care Severe Sepsis* data element because "comfort focused treatment" is synonymous with "comfort care" or "comfort measures." Many of you may have submitted questions related to documentation of "comfort focused care" or "comfort focused treatment" in the past and were told not to use the documentation to select Value 1 (Yes) because "comfort focused care" or a similar term was not listed as an inclusion term. Based on the updated abstraction guidance allowing for terms synonymous with an inclusion term, you would now select Value 1 (Yes) when "comfort focused care" or "comfort focused treatment" is documented in one of the acceptable contexts. Next, I will turn it over to Jennifer to continue our discussion of the updates made to the *Discharge Time* data element.

Jennifer Witt: Thanks, Noel. The *Discharge Time* data element was updated in manual Version 5.15a with new abstraction guidance as well as updated formatting. First, the abstraction guidance on this slide was slightly updated, but it does not include significant changes from the previous guidance for determining the *Discharge Time*. This guidance states, "Use the time that is directly associated with the documentation indicating the patient actually left, such as time patient was discharged from acute inpatient care, left AMA, or transferred out to another facility." As I mentioned, the abstraction guidance previously and continues to state to use the time the patient actually left for the *Discharge Time*. Now, let's review a new sub-bullet point added to this abstraction guidance.

This sub-bullet point was added to address specific scenarios brought to our attention by hospitals and abstractors. This guidance states, "If the patient was discharged from acute inpatient care, was no longer receiving acute inpatient care, but remained in the same hospital, use the time directly associated with the documentation that the patient was discharged from acute inpatient care, such as acute inpatient care discharge and admit to inpatient hospice services. As I mentioned, we frequently received questions related to patients that are discharged from acute inpatient care but remain in the hospital under a different admission. This updated guidance is intended to clarify which time to abstract for the *Discharge Time* in these scenarios. Let's review a scenario related to this updated guidance.

This question is similar to those submitted through the online Q&A tool. This question asks: Which time would you use for the *Discharge Time* based only on the below documentation? Discharge from Med/Surg (acute care): 6/19/2024 at 1600. There is an admission to hospice on 6/19/2024 at 1545 and a discharge to Mercy Hospice Center at 6/20/2024 at 0900. You would use 1600 as the discharge time because the patient was documented as leaving acute inpatient care at this time. You may notice in this scenario that the patient was actually admitted to hospice at 1545. However, if you recall from the updated abstraction guidance we discussed on the previous slide, you would continue to use the time the patient actually left acute inpatient care as the discharge time regardless of the admission time to hospice. Now, let's review the other updates made to the *Discharge Time* data element.

This bullet point received slight updates in the *Discharge Time* data element. It refers to documentation of multiple discharge times. It states, "Use the earliest time that is directly associated with the documentation indicating the patient actually left if there are multiple times documented when the patient was discharged from acute inpatient care or left AMA." It's common for us to receive questions related to documentation of multiple discharge times, and we will take a look at an example scenario in a moment. However, you would use the earliest discharge time available that reflects when the patient actually left.

Now, let's take a look at an example scenario.

With the abstraction guidance we discussed on the previous slide in mind, this question asks: Which time would you use for the *Discharge Time* based only on the below documentation? Discharge Summary of 1700: Gave discharge instructions at 1745. Patient left on stretcher with EMS at 1800. Discharge from acute care at 1830. You would use 1800 as the discharge time because there are multiple discharge times available, but 1800 is the earliest time reflecting when the patient actually left acute inpatient care. Let's review a couple more updates to the *Discharge Time* data element.

These bullet points were also updated in the *Discharge Time* data element. The first bullet point refers to using the time the patient actually left even if there is subsequent documentation, and the second bullet point refers to not using the time of an order to establish the discharge time. For the first bullet point, we often receive questions regarding this scenario due to cases with documentation of care after the discharge time. However, for abstraction purposes, you would continue to use the earliest discharge time reflecting when the patient actually left. Let's take a look at an example scenario.

Keeping the abstraction guidance from the previous slide in mind, this question asks: Which time would you use for the *Discharge Time* based only on the below documentation? There is a discharge summary at 1200. There is a discharge from acute care via wheelchair at 1330. The MAR has a pain med administered at 1345. A RN note at 1400 states, "Pt c/o of HA. PRN pain med given." You would use 1330 as the *Discharge Time* because this is the earliest time available that reflects when the patient actually left. Notice that we disregarded the documentation of the pain med administration on the MAR at 1345 and the nursing documentation at 1400. We did not change the time abstracted for the *Discharge Time* based on the later documentations because we continue to abstract the earliest time the patient actually left for the *Discharge Time* data element.

That covers all of the updates to the *Discharge Time* data element, so let's move onto reviewing the updates to the *Crystalloid Fluid Administration* data element.

First, for the *Crystalloid Fluid Administration* data element, the abstraction guidance on this slide was not updated. However, new guidance was added as sub-bullet points under the guidance on this slide. So, before we look at the updated guidance on the following slide, keep in mind that the abstraction guidance on this slide continues to allow a lesser fluid volume to be used as the target volume when there is physician/APN/PA documentation that includes the lesser volume and a reason for the lesser volume. Now, let's review the new abstraction guidance.

This first new sub-bullet point addresses scenarios where there are multiple physician orders for lesser volume with documented reason. This new sub-bullet point states, "If there are multiple physician/APN/PA orders for a lesser volume with documented reasons, use the total of the lesser volumes ordered within the specified time of six hours prior through three hours after the triggering event." We often receive questions related to this scenario, so let's review a couple examples.

This question is similar to scenarios we frequently receive and the new abstraction guidance on the previous slide specifically addresses. This question asks: Which volume would you use as the target ordered volume? The patient's weight is 70 kg, so the 30 mL/kg is 2100 mL. Then, we can see that *Initial Hypotension* was met at 1400. There are two fluid orders, first at 13:00 for NS 0.9% IV with a volume of 500 mL over one hour. This order includes the comment "CHF." Then, there is a second fluid order at 1700 for NS 0.9% IV with a 500 mL volume over one hour with the order comment of "Fluid overloaded." On the MAR, we can see that 500 mL was started at 1310 and stopped at 1410 and that the second 500 mL was started at 1715 and stopped at 1815. You would use 1000 mL as the target ordered volume because there are multiple fluid orders for lesser volumes that include documented reasons.

So, you would use the total of the lesser volumes ordered because both orders were within the six hours before to three hours after the triggering event which was initial hypotension in this case.

Let's take a look at another scenario. This is another question we frequently receive. This question asks: Which volume would you use as the target ordered volume? In this scenario, the patient weighs 90 kg, so the 30 mL/kg is 2700 mL. Then, the patient met *Septic Shock* at 0900.The physician ordered 1000 mL of normal saline over one hour at 0920 with the comment: "Give 1000 mL to avoid overload." Then, there is a second fluid order at 1130 for 500 mL of normal saline. On the MAR, we can see that 1000 mL was started at 0925 and stopped at 1025, and the 500 mL volume was started at 1145 and stopped at 1245. You would use 1000 mL as the target ordered volume in this scenario because the second fluid order for 500 mL does not include a reason for the lesser volume. If you recall from the new abstraction guidance, you would only use the total of the two volumes if both of the fluids included a reason for the lesser volume. In the scenario above, you would only use the lesser volume of 1000 mL as the target volume because the physician's documentation includes a reason for this lesser volume. Next, you can participate in answering the next knowledge check question.

Would you use 0 mL as the target ordered volume for the *Crystalloid Fluid Administration* data element based only on the MD statement? "Ordering 0 mL due to CHF." A. Yes or B. No. We'll give you a few more seconds to select your answer.

You would select B, No, because the physician's documentation does not include a lesser volume that would be ordered, and 0 mL would not be administered at a rate greater than 125 mL/hr. We frequently see this question because the physician's documentation includes 0 mL and a reason. However, if you review the abstraction guidance in the *Crystalloid Fluid Administration* data element that allows for a lesser volume to be used, that guidance requires a physician/APN/PA order for the lesser volume.

Further in the *Crystalloid Fluid Administration* data element notes for abstraction, you will also find abstraction guidance that requires all fluids used toward the target fluid volume to be administered at greater than 125 mL/hr. Since 0 mL is not an ordered volume and it could not be administered at greater than 125 mL/hr., you would not use 0 mL as the target ordered volume of crystalloid fluid. Now, let's take a look at one more sub-bullet point that was added to the *Crystalloid Fluid Administration* data element.

This new sub-bullet point is also located under the abstraction guidance for using a lesser volume as the target ordered volume, and it applies to cases where there is an order for a lesser volume but there is also documentation indicating the 30 mL/kg volume should be used as the target ordered volume. The new guidance states, "If a lesser volume is ordered and there is physician/APN/PA documentation indicating the target ordered volume is 30 mL/kg within six hours after the lesser volume is ordered, use the 30 mL/kg volume as the target ordered volume." This is also another scenario we frequently receive questions on via the online Q&A tool, so let's take a look at some example scenarios.

This is a frequently asked question we see which is addressed by the new sub-bullet point we discussed on the previous slide. This question asks: Which volume would you use as the target ordered volume? The patient weighs 82 kg, so the 30 mL/kg is 2460 mL. The patient met *Initial Hypotension* at 2100. Then, we can see the physician ordered 250 mL over 30 minutes normal saline IV at 2130 with the comment to use 250 mL due to mild hypotension. Then, there is an MD note at 2315 that states, "Pt met septic shock criteria, ordering 30 mL/kg now." You would use the 30 mL/kg volume, which is 2460 mL, as the target ordered volume based on the physician documentation at 2315, indicating 30 mL/kg was the target fluid volume. You would not use the 250 mL lesser volume as the target ordered volume in this case because the physician's documentation within six hours after ordering the lesser volume states that 30 mL/kg is the target volume. Let's review another scenario.

This question asks: Which volume would you use as the target ordered volume? In this scenario, the patient weighs 75 kg, so the 30 mL/kg is 2250 mL. This patient met *Septic Shock* at 1920. There's an ED MD note that states, "Giving 500 mL due to ESRD." Then, at 1830, there is an order for 500 mL of lactated ringers over 60 minutes. Then, there is a hospital note at 2200 that states, "Hypotension worsening, pt received 500 mL in ED, adding 1750 mL for total of 2250 mL." You would use 2250 mL as the target ordered volume in this case because there is physician documentation within six hours after the order for the lesser fluid volume that indicates the 30 mL/kg volume, which is the 2250 mL volume, is the target volume for the patient. Now, let's review the final updates for manual Version 5.15a which applies to the *Septic Shock Presentation Date* and *Time* data elements.

Similar to the updated abstraction guidance we discussed earlier for the *Severe Sepsis Presentation Date* and *Time* data elements, the *Septic Shock Presentation Date* and *Time* data elements were also updated with new sub-bullet point. The new guidance on this slide applies to the primary bullet point that states, 'Use the earliest documented arrival date and time for patients who enter the Emergency Department with the following." Then, the new guidance states, "Physician/APN/PA documentation that septic shock was present with a documented presentation date and time that is prior to arrival." In this case, you would use the arrival date and time as the *Septic Shock Presentation Date* and *Time* if there is physician/APN/PA documentation that septic shock was present with a date and time that is before the patient arrived. Let's take a look at one last example scenario related to this updated abstraction guidance.

This question asks: Which date and time would you use for the *Septic Shock Presentation Date* and *Time* based on the information below? In the ED MD note, there is documentation: "Call from Dr. Smith at University Geriatric Care states he identified septic shock at 1230 today, 5/15/2024, in the office, and EMS is enroute now." Then, the patient arrived to the ED on 5/15/2024 at 1255, and the patient was admitted to the ICU on 5/15/2024 at 1345.

You would use 5/15/2024 at 1255 as the *Septic Shock Presentation Date* and *Time* because the ED physician's documentation includes a *Septic Shock Presentation Date* and *Time* that was prior to arrival. Based on the updated abstraction guidance we discussed on the previous slide, you would use the arrival date and time to the ED as the *Septic Shock Presentation Date* and *Time*. Now, I would like to review the three knowledge check questions and answers that you participated in answering earlier in the presentation.

Based on feedback we have previously received letting us know that it would be helpful to recap the knowledge check questions asked during the presentation, we wanted to take some time during today presentation to review these Q&As. Let's take a look at the first knowledge check question we asked earlier in the presentation.

The first question asked: Which allowable value would you select for *Severe Sepsis Present* if the MD stated this? "No COVID-19 at 1400." Then, the PA stated: "COVID-19 possible at 1600." A. Value 1 (Yes) or B. Value 2 (No). You would select Value 2 (No) for the *Severe Sepsis Present* data element based on the PA documentation of "COVID-19 possible" after the MD documentation indicating COVID-19 was not present. Upon selecting Value 2 (No) for the *Severe Sepsis Present* data element, the case will be excluded from the measure. These scenarios can be somewhat complex given the various documentation regarding the presence or suspicion of COVID-19. However, if you determine based on the medical record that the documentation indicating COVID-19 was not present or suspected was documented before the physician documentation that COVID-19 was present or suspected, you would select Value 2 (No) for the *Severe Sepsis Present* data element. If the documentation indicating COVID-19 was not present or suspected was within six hours after COVID-19 was documented as present or suspected, then you would disregard the documentation of COVID-19 being present or suspected. In this scenario, you would continue abstracting to determine if *Severe Sepsis* was met.

Next, let's review the knowledge check question related to the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element. The second knowledge check question was: Which allowable value would you select if the *Severe Sepsis Presentation Time* was 1500 and the MD stated, "plan to consult hospice team" at 1700? A. Value 1 (Yes) or B. Value 2 (No). You would select Value 1 (Yes) based on the physician's documentation indicating the plan to consult hospice. Upon selecting Value 1 (Yes) for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element, the case will be excluded from the measure. We frequently see confusion about abstracting the *Directive for Comfort Care or Palliative Care* data element based on the need for the inclusion term to be documented within one of the acceptable contexts. It's generally helpful to first determine if one of the inclusion terms is documented in your medical record. If an inclusion term is documented, then determine if the term is documented within one of the acceptable contexts. The concept here is to exclude cases from the measure that are moving forward with hospice, comfort care, or end of life care because these patients are unlikely to receive severe sepsis and septic shock treatment to meet the measure. However, in some cases there is documentation such as a "discussion of hospice or comfort care" that do not reflect the patient is proceeding with that level of care at that time. Therefore, you would not use inclusion terms that are documented as discussed or similar to exclude the case from the measure. Now, let's take a look at the last knowledge check question we discussed.

This crystalloid fluid administration question was the last knowledge check question and it asked: Would you use 0 mL as the target ordered volume for the *Crystalloid Fluid Administration* data element based only on the MD statement? "Ordering 0 mL due to CHF." A. Yes or B. No. You would select No for this question because you would not use 0 mL as the target ordered volume. As I mentioned earlier, we frequently see this question because the physician's documentation includes 0 mL and a reason. However, since 0 mL is not an ordered volume and 0 mL could not be administered at greater than 125 mL/hr., you would not use 0 mL as the target ordered volume of crystalloid fluid.

It's important to note that while this documentation is not acceptable for using a 0 mL as the target ordered volume, there is additional abstraction guidance in the *Crystalloid Fluid Administration* data element that specifically addresses cases where no crystalloid fluids were ordered. There are specific documentation requirements to meet that abstraction guidance, including physician/APN/PA or nursing documentation that the cardiac output, cardiac index, stroke volume, or stroke volume index were used to determine the patient was not volume or fluid responsive. If the documentation requirements were met, you would select Value 4 (No) for the *Crystalloid Fluid Administration* data element, and the case would be excluded from the measure. You can find the abstraction guidance specific to selecting Value 4 (No) in the *Crystalloid Fluid Administration* data element notes for abstraction.

That concludes our review of the updates and frequently asked questions for specifications manual Version 5.15a. Thank you for participating in our review of the updates. Next, I will turn it over to Noel to review how to submit questions via the QualityNet Inpatient Question and Answer Tool.

Noel Albritton: Thanks, Jennifer. First, if we did not get to your question during the webinar, please submit your question to the QualityNet Inpatient Question and Answer Tool via the link on this slide. If your question is about a specific slide, please include the slide number.

From the qualitynet.cms.gov website you can search for existing questions and answers or submit a new question. To search for an existing question and answer, type the topic or data element into the search box and select Search. All Q&As pertaining to that topic will appear, and you can review the existing Q&As to find your answer. The existing Q&As are for educational purposes, and it's important to ensure the Q&A you are referencing is in agreement with the current manual guidance based on the discharge period you are abstracting. We are continually reviewing and updating the existing Q&As, so it's important to review the existing Q&As often to ensure the responses continue to apply to your questions.

Also, from the Quality Question and Answer Tool page, you can submit your own question by selecting the Ask a Question button. When submitting a question to the support team, you must complete the form which includes your name and contact information. The response to your question will be sent via email to the email address you include on this form.

Next, you will select the program. For abstraction questions for the SEP-1 measure, select Inpatient Measure and Data Element Abstraction. Questions are often submitted to other programs by mistake, and it may take longer to get a response if the question has to be re-routed to the correct support team. So, for SEP-1 abstraction questions, the program to select is Inpatient Measures and Data Element Abstraction.

After selecting the Inpatient Measures and Data Element Abstraction program, you will then select the Topic. For SEP-1 abstraction questions, you can select one of the topics under Hospital Inpatient Sepsis. The topics listed are by the data elements that are included in the SEP-1 measure.

The next required field is the Discharge Period. It is important to select the appropriate discharge period because answers to your questions may vary slightly depending on the manual version.

Next, you will add the subject for your question in the Subject field, and then enter your question into the Please Describe your Question field.

It's important that no PII or PHI is included in your submitted questions. Also, we are unable to receive screenshots or attachments. Submitted abstraction questions should be concise and only include the information specific to the topic being questioned. After you have entered your question, you would next click the Submit Question button. The support team will respond to your abstraction question as quickly as possible. So, that is how you can review existing Q&As and submit a question to the support team. Donna, I will turn it back over to you.

Donna Bullock: Thank you. Now we have time to answer a few questions. The first question is really questions. So, I'll ask this first question. It regards slide

31. Does the colloid need to be infused at a rate greater than 125 ccs an hour to count towards total volume?

Noel Albritton: This is Noel. Yes. So, I think we mentioned that later in the presentation, but all fluids, whether crystalloid or colloid need to be infused at greater than 125 milliliters per hour to be used toward the target volume.

Donna Bullock: OK. There's a second part to the question. I'm sorry, I lost that question. I'll come back to it. OK. Here's our next question: Does the inclusion of a negative COVID test populated within the physician notes without narrative count as documentation that COVID was not present?

Noel Albritton: This is Noel again. So, yes. Whether it's narrative, physician documentation, or they pulled in the negative COVID test into their note. Either one is acceptable for physician documentation, indicating that COVID-19 was not present are suspected.

Donna Bullock: OK. Thank you. What if physician does not document a COVID test was negative, but we can see a negative test result within six hours. This question relates to slide nine.

Noel Albritton: Yes. So, if there's only a negative lab result for the COVID test and it's not documented or noted by the physician, then you would disregard that non negative result from the lab in that case.

You would, assuming there's documentation that COVID-19 was present or suspected, you would continue to select Value 2 (No) for the *Severe Sepsis Present* data element due to their not being physician documentation indicating COVID-19 was not present.

Donna Bullock: Thanks, Noel. This question pertains to Slide 11: If the patient is diagnosed with sepsis on March 2, 2024, but he shows a past medical history of COVID-19 on March 4, would that make a difference?

Noel Albritton: This is Noel, again. So, I don't know. If the documentation of COVID-19 only refers to past medical history, you would disregard that documentation regardless of when it's documented in relation to the

Severe Sepsis Present time. So, just disregard documentation of a recent or past COVID-19 diagnosis.

Donna Bullock: OK, thank you. Slide 10. What happens if the COVID-19 is on active problem list, but there is no date? Can we still select Value 2?

Noel Albritton: This is Noel, again. Yes. So, if COVID-19, as documented by the physician on the active problem list, you would select Value 2 (No) for the *Severe Sepsis Present* data element regardless of the date because the abstraction guidance doesn't require documentation that COVID-19 was present or suspected to be within a specified timeframe. So, documentation that COVID-19 was present or suspected truly, at any point in the medical record, regardless of if it has a timestamp, would be acceptable for selecting Value 2 (No).

Donna Bullock: OK, thank you, Noel. We are referring to slide 15. What if the patient had a positive COVID test and they ordered antibiotics for suspected pneumonia?

Noel Albritton: So, this is Noel again. In this scenario, it depends on how the negative COVID test was documented, I'm sorry, the positive COVID test was documented. So, if the physician/APN/RN documented the COVID test was positive. Then, you would select Value 2 (No) for *Severe Sepsis Present* data element. That would apply regardless if there was further documentation of an infection.

However, if there was only a lab report that showed COVID-19 was positive, you would disregard the lab report because the guidance requires physician/APN/RN documentation to select Value 2 (No). So, if there's only a lab report of the positive COVID test, you would disregard that and continue abstracting. The infection, I believe, was pneumonia in this case with remaining *Severe Sepsis Present* clinical criteria.

Donna Bullock: All right. Here's our next question. Is the problem list to be used when determining if sepsis, severe sepsis or septic shock is present based on physician documentation?

Noel Albritton: So, yes, problem lists can be used, or an active problem list for Criteria A, which is infection, documentation for the *Sepsis Present* data element. There is specific guidance under the criteria and the notes for abstraction that require an infection documented on an active problem list to have further documentation that the infection was active or present. You can look up the exact language. Sorry, I don't have it at the top of my head, but it's under criteria and the notes for abstraction for documentation of severe sepsis or septic shock on an active problem list. Either of those is acceptable to use to select Value 1.

Yes, for the *Severe Sepsis Present* or *Septic Shock Present* data element, documentation of severe sepsis or septic shock does not require further physician documentation to indicate that it's present or active at that time, so you would use the physician documentation. Then, for determining the *Severe Sepsis Presentation Time* or *Septic Shock Presentation Time*, you would use the specified time that's associated with the problem list or the documentation on the problem list. If a specified time is not available, then you would use the note open time or one of the lower priority timestamps that are also included in the abstraction guidance for the presentation time data elements.

Donna Bullock: Thanks, Noel. This question regards slide nine. If a suspected COVID diagnosis is disregarded within six hours of documentation, would you go back to initial presentation to determine severe sepsis time? Would you do so after the cause if documentation was negative?

Noel Albritton: So, this is Noel again. I believe what is occurring here is COVID-19 was documented as present or suspected. Then, within six hours, there was additional physician documentation of COVID-19 not present or suspected. So, we are disregarding the initial documentation of COVID-19. Then, we're trying to determine the *Severe Sepsis Presentation Time*. You would continue to use the earliest severe sepsis presentation time available in that case. You would not use or begin looking for severe sepsis presentation time only after the documentation indicating COVID-19 was not present. Always, when you're abstracting this for *Severe Sepsis Presentation Time,* use the earliest presentation time available.

Donna Bullock: Thanks. Noel. Is there any time limit for *Directive for Comfort Care or Palliative Care* that is found in chart prior to severe sepsis?

Noel Albritton: No. There's no time limit prior to severe sepsis, the specified timeframe for the *Directive for Comfort Care or Palliative Care*. Palliative care is before or within six hours after, so, as far as looking for acceptable documentation before the *Severe Sepsis Presentation Time*, there is no time limit. It's only within the six hours after that, you can't go, I guess, past.

Donna Bullock: Thanks, Noel. This is our next question: The palliative care consult is entered at 1200. Time 0 is 1300, but the note from palliative care at 1500 states, "Patient would like full interventions, pain, management suggestions given." Would this still be yes for palliative exclusion? Slide 22, Sorry.

Noel Albritton: This is Noel again. The answer for this is yes. You would continue to select Value 1 (Yes) for the *Directive for Comfort Care or Palliative Care* data element. That's based on the palliative care consult that's entered within the or documented by the physician within the specified timeframe. The later documentation about the patient would like to continue full interventions, you would disregard that documentation and just continue to select Value 1 (Yes).

Donna Bullock: OK. The next question pertains to Slide 25. Does the time when the patient signed the discharge instructions count as discharge time if patient didn't receive care after that time?

Noel Albritton: This is Noel. So, no. The time when the patient signs the discharge instructions would not be used to determine the discharge time. If there was documentation, likely not in the discharge instructions, but documentation indicating the patient left at that time, or was discharged at that time, that's the time you would use to determine the discharge time. Yet, strictly the time that they sign the discharge instructions alone, you would not use that to determine the discharge time.

Donna Bullock: OK. The next one has a range of slides, 24 to 29. For scenarios of AMA, the documentation does not include the time the patient actually left, but it states that the patient was no longer found to be within the hospital. What

time should be used in the documentation note? If it's a specified time, the patient left is not included, should UTD be extracted?

Noel Albritton: Yes. So, for patients that leave AMA, if you have no documentation with a specified time that states patient left AMA with that timestamp, that would be the time you would use or documentation with a specific time that dates, I believe, he was no longer found to be in the hospital. That would also be acceptable for determining the discharge time since it indicates no patient. As far as, if you are unable to determine based on the documentation when the patient left AMA or was discharged, then, yes, you would select UTD for the discharge time data element.

Donna Bullock: All right. This question pertains to slide 33. What if only one of the orders included a note about volume ordered or CHF?

Noel Albritton: This is Noel again. If only one of these orders included a reason for the lesser volume, then you would use that that order and that volume as the target volumes. So, let's say if the 1 at 1500 included the reason for the 500-milliliter volume and the reason is CHF and there's another order at 7500. With the volume of 500, that does not include a reason, then you would use the 500 milliliters in that case because the physician documented that lesser volume with the reason. I saw a number of questions on slide 33, asking about the timing and the orders for this particular scenario.

We're determining the target volume to use more than determining which allowable value should be selected for the *Crystalloid Fluids Administration* data element. In this situation, where there's two orders for lesser volumes that both include a reason, based on the updated abstraction guidance, we would combine those two orders for 500 milliliters because they both have a reason. Then, once we determine what the target volume is, we'll determine if the target volume was ordered and started within the specified timeframe for the data element. That will lead us to determining which allowable value should be selected, based on if the orders and the target volume was started and completed. Hopefully, that clarifies some of those questions.

Donna Bullock: Thank you. This question pertains to slide 35. Is there a situation where 0 milliliters is a volume due to an acceptable reason for a lesser volume? So, this is again, as far as a 0 milliliter volume.

Noel Albritton: Yes. For the abstraction guidance, regarding a lesser volume where the physician documents a lesser volume, with a reason, no, zero volume would not meet that abstraction guidance. However, I think Jennifer mentioned and the later knowledge check review questioned that there are scenarios where Value 4 can be selected for the *Crystalloid Fluids Administration* data element based on no fluids being given. Data is an abstraction guidance towards the bottom of the *Crystalloid Fluids Administration* data element and it lays out the specific documentation requirements for selecting Value 4 when 0 milliliters were ordered or given to the patient.

Donna Bullock: Thank you. What if the MD documents and recommends hospice but no order is placed.

Noel Albritton: So, in this scenario, for the *Directive for Comfort Care or Palliative Care* data element, you would select Value 1 (Yes) assuming the physician documented recommending palliative care, comfort care, hospice, is within the specified timeframe that's before, within six hours or after the severe sepsis presentation time.

That's because the inclusion term includes hospice, comfort care, palliative care, and is included within one of the acceptable contexts and recommendations for hospice, palliative care. All of that is acceptable context for selecting Value 1 (Yes).

Donna Bullock: Thank you. This question pertains to slide 31. It's the second question you answered. This is the follow up question. Is albumen an acceptable colloid? I'm sorry. Let me go ahead and do the part two. Why aren't colloid names listed under acceptable fluids?

Noel Albritton: So. Albumen will likely be an acceptable colloid. The abstraction guidance for does not include an all-inclusive list. So, there are some examples of acceptable crystalloid fluids in the inclusion guidelines in the

Crystalloid fluid administration data element. Then if the documentation requirements are met to use Colloids, that is acceptable for meeting target volume. You can reference a medical resource of some kind, physician, pharmacist, medical literature for determining the type of a particular fluid. That would be our suggestion, simply because there's not a list of all-inclusive or an all-inclusive list of fluids and the abstraction guidance.

Donna Bullock: Thanks, Noel. Next question is: Would you abstract patient's death time as discharge time?

Noel Albritton: Yes. This is Noel again. Sorry. Death time, expired time, pronounce time should all be acceptable or will be acceptable for determining the discharge time. There may be some other terminology. The abstraction guidance refers to the expired time or pronounce time. As long as it's reflecting the time of death or expired time, it's acceptable for determining the discharge time.

Donna Bullock: Thank you. Would a case be excluded if the documentation of plan to order a palliative care consult, but the actual order for the consult is outside of the timeframe?

Noel Albritton: Yes. So, you would select Value 1 (Yes) for the *Directive for Comfort Care or Palliative Care* data element based on the physician documentation that they are planning to order care consult.

Again, that is based on the inclusion term palliative care consult or palliative consult being documented within one of the acceptable contexts, which is a plan in this case. As long as that's documented within the specified timeframe, you would select Value 1 (Yes) regardless of when the actual order for the console was placed.

Donna Bullock: Thank you. If the provider only writes severe sepsis met presentation, would you still take the date and time of arrival?

Noel Albritton: No. In that case, we would not abstract the time of ER/ED arrival based on documentation like severe sepsis on presentation. That's due to because it doesn't specify if it's present on arrival, present on admission, etc. In that

case, we would use the specified time for the physician documentation that includes severe sepsis. Then, if the specified time for that documentation is not available, we would use the note open time or one of the lower priority timestamps included in the abstraction guidance.

Donna Bullock: Thank you, Noel. Here is our next question. If the provider does not document "met septic shock criteria," but the patient meets criteria, for example, lactic acid 5.0, meeting certain criteria with source of infection, can you use this value to determine septic shock?

Noel Albritton: Yes. So, the *Severe Sepsis Present* data element or *Septic Shock Present* data element can be met by physician documentation, let's just say for the *Septic Shock Present* data element, it can be met by physician documentation of septic shock, or it can be met by criteria, which would be severe sepsis, with an initial lactate level, result greater than four, or equal to four, or severe sepsis with persistent hypotension. So, in this case, in the question, if the initial lactate was 5 and the patient met SIRS criteria and had a source of infection, that would meet all three clinical criteria for establishing severe sepsis. Then severe sepsis with that initial lactate level of 5 would meet the criteria for septic shock. So, in that case, you wouldn't necessarily need physician documentation of septic shock to select Value 1 (Yes). You could select Value 1 (Yes) based on meeting severe sepsis with an initial lactate level result.

Donna Bullock: Thank you. Here's our next question. If there is an order for consult for palliative care, and the reason listed in the consult is discuss goals of care, would that exclude the patient?

Noel Albritton: This Noel, again. Yes. So, the physician order for the consult palliative care or palliative consult would meet the guidance for selecting Value 1 (Yes) assuming that it was documented within the specified timeframe, the reason or the console, um, like discussion of goals or discussion of care, pain, management, any of that you would disregard because the data element directs for comfort care, palliative care would be met by the physician console for palliative care.

Donna Bullock: All right. We have time for just a few more questions. Here's our next one. Would either of these scenarios meet the infection guidelines, or would it be excluded? 1. Provider documents patient has influenza A and pneumonia. No further notation about whether it is viral or bacterial. 2. Provider documents patient has influenza A with bacterial pneumonia in section.

Noel Albritton: This is Noel again. So, if I heard you correctly, in both of those cases you would disregard the viral infection documentation and use the bacterial infection documentation to meet criteria A. I'm sorry, Donna, can you repeat?

Donna Bullock: I'm sorry. Did you want me to read it again?

Noel Albritton: Yes, if you would, just the scenarios would be fine, OK?

Donna Bullock: Here's the first scenario. Provider documents patient has influenza A and pneumonia, but no further notation about whether it is viral or bacterial. Number two is provider documents patient has influenza A with bacterial pneumonia in section.

Noel Albritton: Thank you. So, for the provider documentation, influenza and pneumonia, you would disregard the viral infection documentation and use the documentation of pneumonia to meet criteria. Some of that is dependent on how this is documented in the actual medical record.

If the documentation reflected influenza A with pneumonia or something similar, then you would disregard that all of that documentation influenza with pneumonia because that would be attributing pneumonia to the viral infection. But as like in this case, we have influenza and pneumonia. You would disregard the viral infection, use the bacterial infection documentation for provider documentation, patient has influenza A with bacterial pneumonia infection. That would be similar. You would disregard the influenza A and use the bacterial pneumonia infection because that's clearly saying that that is not a viral infection. Some of that is dependent on medical record and how it's documented in there. So, if

you have questions or more questions about that scenario, feel free to submit it through the Q&A tool.

Donna Bullock: Thank you very much, Noel. We are just about out of time for questions. This is going to be our last one: If severe sepsis was not met, and the physician documented "severe sepsis resolved," should we select Value 1 (Yes) for the *Severe Sepsis* data element?

Noel Albritton: So, no, in that case, you would select Value 2 (No) for the *Severe Sepsis* data element because severe sepsis was not met either by clinical criteria or physician documentation, and documentation of "severe sepsis resolved" is documentation of severe sepsis, one of the negative qualifiers, so you would disregard that documentation. So, you would select Value 2 (No) in that case, and it would be excluded from the measure.

Donna Bullock: Alright, Thank, Noel. That is all the time we have for questions now.

This event has been approved for 1.5 continuing education credits. If you registered for today's event, an email, with the link to the survey and the continuing education credit information, will be sent to you within two business days. If you did not register for the event, please obtain this email from someone who did register. More information about our continuing education processes can be found by clicking the link on this slide.

That concludes today's presentation. Thank you so much for joining us, and enjoy the rest of your day.