Hospital Inpatient Quality Reporting (IQR) Program

Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) Version 5.17a Review and Updates Presentation Transcript

Speakers

Noel Albritton, MSN, RN, Lead Solutions Specialist
Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor

Jennifer Witt, RN, Senior Quality Improvement Facilitator
Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor

Moderator

Donna Bullock, MPH, BSN, RN
Program Lead, Hospital IQR Program
Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

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Donna Bullock: Hello and welcome to today's event, *Severe Sepsis and Septic Shock: Management Bundle Version 5.17a Review and Updates.* My name is Donna Bullock, and I am the [Hospital] Inpatient Quality Reporting Program lead for the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support. I will be your moderator for today's event. Before we begin, I would like to make a few announcements. If you registered for today's event, we emailed you a link to the slides a short time ago. If you did not get this link, the slides are available on the Quality Reporting Center website. That's www.QualitReportingCenter.com. During this event, you can also download the slides by clicking the Handouts link. This webinar is being recorded. The recording, a transcript of the event, and a question-and-answer summary will be available on the Quality Reporting Center website in the near future. This event has been approved for one continuing education credit. More information will be provided at the end of the webinar.

Our speakers for today's event are Noel Albritton, Lead Solutions Specialist for the Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor, and Jennifer Witt, Senior Quality Improvement Facilitator 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 SEP-1 measure and guidance in Version 5.17a of the specifications manual and to respond to frequently asked questions.

At the conclusion of the event, participants will be able to understand and interpret the guidance in Version 5.17a of the specifications manual.

This slide is a reference for the acronyms and abbreviations that we may use during today's presentation.

Noel will go over the process to submit follow-up webinar questions later in the webinar. Thank you for your attention. I will now turn the presentation over to Noel.

Noel Albritton: Thanks, Donna. Hello, everyone, and thank you for joining us. Today, we will review the guidance for the SEP-1 measure in specifications manual Version 5.17a. We will review guidance that was updated in manual Version 5.17a, as well as review guidance that is frequently asked about. Updated guidance to manual Version 5.17a is noted in yellow highlight throughout the presentation and in the specifications manual, and abstraction guidance, noted in blue highlight, reflects guidance updated as an addendum to manual Version 5.17a. Our discussion and slides today will be in order of the SEP-1 algorithm. You can find the SEP-1 algorithm and the hospital inpatient specifications manual on the QualityNet website at QualityNet.cms.gov.

Let's begin with the updated abstraction guidance in the *Transfer from Another Hospital or ASC* data element. With the emergence of hospital at home programs and questions we have received from abstractors and hospitals, the abstraction guidance was updated to state: Select "No" for transfers from acute hospital care at home programs unless it is documented as a transfer from an outside hospital. In this scenario, if your hospital has an acute hospital care at home program and a patient is transferred from the acute hospital care at home program to a bed within your hospital, you would select "No" for the *Transfer from Another Hospital or ASC* data element. However, if the patient was in an acute hospital care at home program that was part of another hospital and the patient was received as a transfer to your hospital, you would select "Yes" for the transfer data element. Let's take a look at question related to this scenario.

This question asks: Would you select "Yes" or "No" for the *Transfer From Another Hospital or ASC* data element based only on the documentation below? "Patient found to meet SIRS criteria and organ dysfunction at our hospital at home program. Decision was made to transfer patient to our MICU."

You would select "No" for the *Transfer From Another Hospital or ASC* data element in this scenario because the documentation reflects the patient was in the hospital's acute hospital care at home program and was transferred to the hospital's MICU. Let's take a look at one more question related to the *Transfer From Another Hospital or ASC* data element.

This question is also for the transfer data element. It asks: Would you select "Yes" or "No" for the *Transfer From Another Hospital or ASC* data element based only on the documentation below? "Patient transferred from prison infirmary." You would select "No" for the transfer data element in this scenario because transfers from a prison or jail infirmary or medical unit is not listed in the abstraction guidance as one of the acceptable locations for selecting "Yes."

Next, you can participate in answering a Knowledge Check question.

Would you select "Yes" or "No" for the *Transfer From Another Hospital or ASC* data element based only on this documentation? "Patient transferred via ambulance from Mercy Recovery (drug rehab)." A. Yes or B. No. We'll give you a few more seconds to select your answer.

Select B. No because patients received as a transfer from a drug rehab would not be excluded from the measure as a transfer from another hospital or ASC.

Let's look at another transfer scenario that we often receive questions about.

Would you select "Yes" or "No" for the *Transfer From Another Hospital or ASC* data element based only on the documentation below? "Patient received as a transfer from an outside ED but refused ambulance and arrived via private vehicle." You would select "Yes" for the transfer data element based on this documentation because it refers to the patient received as a transfer from the outside or satellite ED.

Now, let's move on and review the updates to the *Severe Sepsis Present* data element.

There were several updates to the *Severe Sepsis Present* data element in manual Version 5.17a. The first update we'll discuss is related to an FDA-approved biomarker test for sepsis detection. The updated abstraction guidance on this slide is found under the infection criteria in the *Severe Sepsis Present* data element. It states, "A physician/APN/PA order for an FDA-approved biomarker test for sepsis detection can be considered documentation of suspicion of an infection, regardless of whether the result of the test indicates sepsis." This new abstraction guidance is specific to an FDA-approved test or device that is used to detect sepsis. Therefore, you would not use an order for a lab test to meet this abstraction guidance. Also, this new abstraction guidance does not require further documentation of an infection within the order for the FDA-approved test to meet this abstraction guidance.

Let's take a look at an example scenario.

With the updated abstraction guidance we discussed on the previous slide in mind, this question asks: Would you use the MD documentation below to meet *Severe Sepsis Present* criteria A (infection)? On 2/19/2025 at 1600, there is an ED MD Order Set that includes a Sepsis Biomarker Test that is FDA approved, a CBC, CMP, and a Lactic Acid.

Yes, the ED MD order on 2/19/25 at 1600 for the FDA-approved Sepsis Biomarker Test is acceptable for meeting criteria A (infection) based on the updated abstraction guidance. I will point out here that this example includes an order for a Sepsis Biomarker Test that is FDA-approved, but an order for these tests in your medical record will most likely include the name of the FDA-approved test, which is acceptable. Before we move on to other updates, I do want to point out here that the abstraction guidance does not include a list of FDA-approved biomarker tests for sepsis detection. Therefore, you may consult a medical resource such as literature to determine if a biomarker test is FDA-approved for sepsis detection.

Next, let's take a look at other updates made in the *Severe Sepsis Present* data element.

The next update and abstraction guidance we'll discuss is related to documentation of COVID-19 and coronavirus. The abstraction guidance continues to include guidance for selecting Value 2 if there is physician/APN/PA documentation that coronavirus or COVID-19 is suspected or present. This statement was added to this existing abstraction guidance: "Do not use documentation of COVID-19 or coronavirus qualified with a term synonymous with low suspicion, doubt, or unlikely." This update was made based on questions and feedback from abstractors and hospitals that were finding documentation of COVID-19 or coronavirus with a term such as low suspicion, doubt, or unlikely. Therefore, based on the updated abstraction guidance, you would disregard documentation of COVID-19 or coronavirus with a term such as low suspicion, doubt, or unlikely because these do not reflect COVID-19 or coronavirus is present or suspected. Before we take a look at the other updated abstraction guidance, I would like to review one portion of the abstraction guidance and a scenario we still receive questions on related to COVID-19.

This portion of the abstraction guidance in the *Severe Sepsis Present* data element was not updated in manual Version 5.17a. However, we still receive questions from abstractors via the online Q&A tool, so let's review the abstraction guidance and an example scenario. The abstraction guidance refers to not using 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 after the initial documentation of coronavirus or COVID-19. Let's take a look at an example scenario we frequently receive via the online Q&A tool.

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 April 22 at 0630 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 April 22 at 1130, 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.

Let's review one more scenario that is similar to this one. As I mentioned, this scenario is very similar to the previous one; however there is one significant difference. The question again 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 ED physician documentation on January 5 at 0700 that states, "Patient is symptomatic for COVID-19. Awaiting test results." Then, on January 5 at 0930, there is a hospitalist MD note where the lab results have been pulled into the physician's note and indicate the COVID-19 test was negative. The answer is "No." You would disregard the ED physician documentation ("Patient is symptomatic for COVID-19.") because the hospitalist documentation includes the pulled in COVID-19 lab result that was negative which is acceptable physician documentation for indicating COVID-19 was not present.

Next, let's review the updated abstraction guidance related to mechanical ventilation. The abstraction guidance for determining the time of organ dysfunction based on mechanical ventilation was updated in manual Version 5.17a. The updated guidance states, "Use the time when mechanical ventilation was started, the earliest time directly associated with the patient being on mechanical ventilation, or the time when the mechanical ventilation changed from intermittent to continuous."

The updated guidance ("the earliest time directly associated with the patient being on mechanical ventilation") was added to the existing abstraction guidance based on feedback received from hospitals and abstractors. The most frequent scenarios related to this abstraction guidance that we received via the online Q&A tool were related to scenarios where a start time for the mechanical ventilation is not available.

With the updated abstraction guidance in manual Version 5.17a, if a start time for mechanical ventilation was not available, you can use the earliest time directly associated with the patient being on mechanical ventilation to establish organ dysfunction criteria. Next, let's take a look at an example scenario.

The question asks: What time would you use for mechanical ventilation when establishing organ dysfunction criteria for the *Severe Sepsis Present* data element based only on the documentation below? An intubation flowsheet at 1600 states, "ET placement." Then, a respiratory therapy note at 1730 states, "Pt intubated and on a vent." You would use 1730 as the time for the mechanical ventilation based on the updated abstraction guidance allowing for the earliest time directly associated with the patient being on mechanical ventilation. Next, you can participate in answering the following Knowledge Check questions.

Would you use the BiPAP to meet organ dysfunction criteria for the *Severe Sepsis Present* data element if respiratory therapy stated, "Placed on BiPAP at 1500." Also, physician documentation at 1630 stated, "BiPAP discontinued." A. Yes or B. No. We'll give you a few more seconds to select your answer.

Would you use the BiPAP to meet organ dysfunction criteria for the *Severe Sepsis Present* data element if RT stated, "placed on BiPAP at 1500" and physician documentation at 1630 stated, "BiPAP discontinued?" Yes. No. Select A, Yes, because the documentation of the BiPAP being started at 1500 is acceptable for establishing organ dysfunction criteria. Now let's take a look at one more update to the *Severe Sepsis Present* data element.

This abstraction guidance was updated in manual Version 5.17a based on questions and scenarios submitted by abstractors via the online Q&A tool. This abstraction guidance refers to using SIRS criteria or a sign of organ dysfunction when there is conflicting documentation within the same documentation.

In these scenarios, there is physician/APN/PA documentation that the SIRS criteria or sign of organ dysfunction is normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source, AND within the same documentation, the SIRS criterion or sign of organ dysfunction is documented as due to an acute condition, acute on chronic condition, infection, severe sepsis, or septic shock. Let's review an example scenario related to this updated guidance.

This question asks: Would you use the abnormal lactate to establish organ dysfunction for the *Severe Sepsis Present* data element based only on the physician documentation below? Physician documentation states, "Pt with lactic acidosis r/t to seizure but also on metformin." Yes, you would use the abnormal lactate value to meet organ dysfunction criteria. Although the physician's documentation includes the term "lactic acidosis" and the medication, it also includes the acute condition of seizure. Therefore, since there is conflicting documentation within the same documentation, you would use the abnormal lactate value to meet criteria.

Now, I will turn it over to Jennifer to review the updates to the *Initial Lactate Level Result* data element.

Jennifer Witt: Thanks, Noel. The *Initial Lactate Level Result* data element was updated to include abstraction guidance for selecting the appropriate allowable value. The updated abstraction guidance states, "Select Value '1' if the initial lactate was obtained in the operating room, in interventional radiology, during cardiopulmonary arrest, or during procedural/conscious sedation." You are likely familiar with this abstraction guidance because similar guidance is included in other data elements for the measure. However, for the *Initial Lactate Level Result* data element, when you select Value 1 based on this new abstraction guidance, the *Repeat Lactate Level Collection* data element would not be abstracted, and the *Initial Lactate Level Result* value would not be used to meet septic shock clinical criteria. The abnormal lactate value is not used when the lactate is collected in the OR, in interventional radiology, during CPR, or during procedural/conscious sedation because the events occurring at those times can impact the result of the lactate value.

Let's review one more update to the *Initial Lactate Level Result* data element. Similar to our earlier discussion of the updates to the *Severe Sepsis Present* data element, the *Initial Lactate Level Result* data element also received the update related to conflicting documentation within the same documentation. A similar update was made to the *Initial Hypotension* and *Persistent Hypotension* data elements, so let's take a quick look at the updates to those data elements.

As I mentioned, the update to the abstraction guidance for conflicting documentation within the same documentation was also updated in both the *Initial Hypotension* and *the Persistent Hypotension* data elements. The update is the same in both of these data elements and reflects that you would use the abnormal blood pressure reading when there is conflicting documentation within the same documentation. There's one more data element where this update was made, so let's review this update in the *Septic Shock Present* data element.

As I mentioned, the updated guidance is the same in the *Septic Shock Present* data element. As a review of how this would apply during abstraction of the *Septic Shock Present* data element, if you selected Value 2 (No) for the *Initial Hypotension* data element, the case would proceed in the algorithm to the *Septic Shock Present* data element. Then, you would determine if septic shock was met by physician/APN/PA documentation or by clinical criteria which include severe sepsis with an initial lactate level result greater than or equal to 4 or severe sepsis with persistent hypotension. There's one frequently asked question related to meeting septic shock by clinical criteria that I would like to review.

This question asks: Would you use *Persistent Hypotension* to meet *Septic Shock Present* clinical criteria based only on the information below? Severe Sepsis Present: Value 1 (Yes). Severe Sepsis Presentation Time: 1300. Initial Hypotension: Value 2 (No). "Septic shock" was not documented by physician/APN/PA. Initial lactate value was less than 2. Persistent Hypotension: Value 1 (Yes) based on hypotensive readings was at 1330 and 1345.

Yes, you would use *Severe Sepsis* and *Persistent Hypotension* to meet the septic shock clinical criteria. We often receive this question because Value 2 (No) was selected for the *Initial Hypotension* data element. In this scenario, the case proceeds to the *Septic Shock Present* data element before the *Crystalloid Fluid Administration* and *Persistent Hypotension* data elements are reached in the algorithm. However, you would continue to determine if the septic shock clinical criteria were met upon reaching the *Septic Shock Present* data element. Next, let's review the updates to the *Septic Shock Presentation Date* and *Time* data elements.

The *Septic Shock Presentation Date* and *Septic Shock Presentation Time* received a similar update in manual Version 5.17a. This slide includes the update for the *Septic Shock Presentation Date* data element which now includes the abstraction guidance for using other time stamps intended to identify the result dates from the lab are acceptable with a terminology reference such as a policy, key, or legend. Let's review the update to the *Septic Shock Presentation Time* data element and then we will take a look at an example scenario.

This slide includes the updated guidance for the *Septic Shock Presentation Time* data element. Again, it includes the abstraction guidance for using other time stamps intended to identify the result time from the lab are acceptable with a terminology reference such as a policy, key, or legend. Now, let's review a scenario we frequently receive where this updated abstraction guidance applies.

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 physician note, it states, "Pt. met severe sepsis on 04/28/2025 at 1600." Initial lactate result was 4.5. There is no result time from the lab available. The lab report has a verified time of 4/28/2025 at 1630 for lactate of 4.5. The lab report legend states, "Verified time stamps indicate the result date and time of labs." You would use 4/28/2025 at 1630 as the *Septic Shock Presentation Date* and *Time* in this scenario. Next, let's move on and review the updates to the *Crystalloid Fluid Administration* data element in manual Version 5.17a.

The abstraction guidance for using a lesser volume as the target volume in the *Crystalloid Fluid Administration* data element was updated in manual Version 5.17a. The abstraction guidance continues to allow for a lesser volume to be used as the target volume when the lesser volume is ordered by a physician/APN/PA and there is physician/APN/PA documentation of a reason for the lesser volume. However, the updated abstraction guidance removed the previous requirement for the ordering physician/APN/PA to also document the lesser volume and reason. The updated portion of the abstraction guidance states, "There is physician/APN/PA documentation within a single source, such as a note or order in the medical record including all of the following…" which must include the lesser volume and a reason for ordering the lesser volume. So, based on the updated abstraction guidance, there still must be physician/APN/PA documentation of the lesser volume and a reason, but the abstraction guidance does not require the same physician/APN/PA that ordered the lesser volume to also document the lesser volume and reason.

Let's review an example scenario. This question asks: Which volume would you use as the target ordered volume? Patient weight 60 kg. Thirty mL/kg equals 1800 mL. Initial Hypotension was at 09:00. The IV fluid order at 09:30 was NS 0.9% IV volume 500 mL over 1 hr. The order was by Dr. Smith. Hospitalist APN Note at 11:30 states, "Pt hypotension resolved after 500 mL" On the MAR: 09:35 new bag 500 mL NS was stopped at 10:35. You would use 500 mL as the target volume based on this documentation. Next, you can participate in answering a Knowledge Check question.

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

Select B. No. because the PA'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.

Since questions related to using a lesser volume as the target volume are commonly submitted via the online Q&A tool, let's review the remaining abstraction guidance for using a lesser volume and more example scenarios.

The two sub-bullet points on this slide are included under the abstraction guidance for using a lesser volume as the target volume. We would encourage you to review the complete abstraction guidance included in the Notes for Abstraction in the *Crystalloid Fluid Administration* data element. The first sub-bullet point on this slide addresses multiple physician/APN/PA orders for lesser volumes with documented reasons and states to use the total of the lesser volumes ordered within the specified time of six hours prior through three hours after the triggering event. The second sub-bullet point address physician/APN/PA documentation indicating the target volume is 30 mL/kg within six hours after a lesser volume was ordered. We frequently receive questions via the online Q&A tool that are related to both of these bullet points, so let's review some example scenarios.

We frequently receive scenarios such as this one which is related to the abstraction guidance specific to multiple fluid orders for lesser volumes. This questions asks: Which volume would you use as the target ordered volume? Patient weighs 80 kg, 30 mL/kg equals 2400 mL Septic shock present at 15:00. IV fluid orders at 13:20 include NS 0.9% IV volume 1000 mL over 1 hr. The order comments: Limit to 1000 mL due to CKD. At 15:30: NS 0.9% IV with a volume of 500 mL over 1 hr. On the MAR at 13:25, there's a new bag of 1000 mL NS with a stop time of 14:25. At 15:45, there's a new bag of 500 mL NS and stop time of 16:45.

You would use 1000 mL as the target volume based on the physician order for 1000 mL and documentation of the reason for this volume, which is CKD in this example. Let's take a look at another scenario.

This questions asks: Which volume would you use as the target ordered volume? Patient weighs 90 kg, and 30 mL/kg equals 2700 mL. Septic shock was present at 21:00. IV fluid orders at 20:45 were NS 0.9% IV 500 mL at 1000 mL/hr.

At 21:30, there is NS 0.9% IV volume 20 mL/kg at 1000 mL/hr. Hospitalist MD note at 21:30 states, "Initially ordered 500 mL for hypotension, now with septic shock, adding 20 mL/kg of NS." On the MAR at 20:50, there is a new bag of 500 mL NS with a stop time at 21:20. At 21:45, there is a new bag of 1000 mL of NS with a stop time of 22:45. At 22:45, there's a new bag of 1000 mL NS and stop time 23:33. MAR comment states, "Stopped at 23:33 following completion of 800 mL." You would use 2300 mL as the target volume in this scenario because there are multiple orders for lesser volumes, and the lesser volumes have documented reasons. Let's take a look at another scenario that's a little different that this one.

This question asks: Which volume would you use as the target ordered volume? Patient weighs 112 kg, and 30 mL/kg equals 3360 mL. The ideal body weight is 75 kg, and 30 mL/kg would equal 2250 mL. Initial hypotension was at 18:00. IV fluid orders at 18:25 were NS 0.9% IV volume 1000 mL over 60 minutes. Order comments: "Monitoring fluid overload." Physician note at 19:15 states, "Bolus sepsis fluids 30 mL/kg per IBW due to obesity." You would use 2250 mL as the target volume based on the physician documentation indicating 30 mL/kg was the target volume based on using the patient's ideal body weight. Let's review one more scenario.

This question asks: Which volume would you use as the target ordered volume? Patient weighs 82 kg, and 30 mL/kg equals 2460 mL. Initial hypotension at 05:20. IV fluid orders at 03:15 were NS 0.9% IV volume 1000 mL over 60 minutes. Order comments: "Hx of HTN." At 06:15, orders call for NS 0.9% IV volume 1500 mL at 1000 mL/hr. ED PA note at 07:45 states, "Gave 2500 mL IV fluids total with improvement." You would use 2460 mL as the target volume in this case based on the physician documentation at 0745 referring to 2500 mL being the total volume for the patient and the 30 mL/kg volume being 2460 mL.

That concludes our review of the updated abstraction guidance in manual Version 5.17a and example scenarios, but let's take a few moments to review the Knowledge Check questions.

We've received feedback previously that it's helpful to recap the Knowledge Check questions asked during the presentation, so let's take a look at the Knowledge Check questions we asked earlier in today's presentation.

The first question asked was: Would you select "Yes" or "No" for the *Transfer From Another Hospital or ASC* data element based only on this documentation: "Patient transferred via ambulance from Mercy Recovery (drug rehab)." The answer was to Select B, No, because patients received as a transfer from a drug rehab would not be excluded from the measure as a transfer from another hospital or ASC. As we mentioned earlier, the Notes for Abstraction in the transfer data element include a list of specific locations for selecting "Yes" when the patient received as a transfer from those locations. Often, we receive questions such as the one this slide related to drug rehab or other documentation in medical records that simply refers to patients transferring from a "rehab" are asked because the abstraction guidance refers to selecting "Yes" when the patient is received as a transfer from an acute rehab. However, acute rehabilitation is another level of care, and the abstraction guidance for selecting "Yes" for transfers received from acute rehabilitation does not apply to patients received from a drug rehab.

Let's take a look at the next Knowledge Check question. The second Knowledge Check question was: Would you use the BiPAP to meet organ dysfunction criteria for the *Severe Sepsis Present* data element if RT stated this? "Patient was on BiPAP at 1500." Physician documentation at 1630 stated, "BiPAP discontinued." The answer was to select A. Yes because the documentation of the BiPAP being started at 1500 is acceptable for establishing organ dysfunction criteria. This type of question is often submitted via the online Q&A tool because there is documentation that the mechanical ventilation was discontinued within a short time after it was started on the patient. However, the abstraction guidance does not refer to disregarding the initiation of the mechanical ventilation based on documentation that it was discontinued.

Therefore, you would continue using the initiation of mechanical ventilation to meet severe sepsis clinical criteria.

Now let's take a look at the last Knowledge Check question. The last Knowledge Check question was: Would you use 0 mL as the target ordered volume for the *Crystalloid Fluid Administration* data element based only on this PA statement" "Ordering 0 mL due to overload." The answer was to select B. No because the PA'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 often receive this type of question in the online Q&A tool because the documentation includes 0 mL and a reason. However, as we mentioned earlier, 0 mL is not an ordered lesser volume of fluids, nor does 0 mL meet the remaining abstraction guidance to select Value 1 (Yes) for the data element. Generally, in this scenario, you would select Value "3" (No) for the *Crystalloid Fluid Administration* data element due to the target volume not being started within the specified time frame.

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.

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.

You may reference slides 49 through 53 of this presentation at your convenience for assistance with submitting a question to the support team. Donna, I will turn it back over to you.

Donna Bullock: Thank you, Noel. We are near the end of the time allotted for our webinar. However, we do have a few minutes now to answer some questions from our audience. If we do not get to your question, remember there will be a question-and-answer summary posted to the Quality Reporting Center website in the near future.

You can also send your question to the sepsis team using the QualityNet Question and Answer Tool. All right. This is our first question: If a provider documents low suspicion for bacterial pneumonia, is this a positive qualifier for an infection?

Noel Albritton: This is Noel. I can take that. So, if a provider documents low suspicion for bacterial infection, you would disregard that documentation because it's similar to the negative qualifiers like less likely or doubt. So, you would not use that as a positive qualifier for infection documentation. You would just disregard low suspicion for bacterial pneumonia.

Donna Bullock: OK. Thank you. Now, I have two questions about slide 21. Could we get back to slide 21? OK. The first question for slide 21 says: Abstractors have been advised not to use flow sheets for BiPAP, CPAP, ventilation initiation. Does this still apply? Must it come from specific documentation from a note?

Noel Albritton: This is Noel again. So, documentation of mechanical ventilation, BIPAP, CPAP, a ventilator on a flow sheet is acceptable. The abstraction guidance doesn't limit where documentation of a mechanical ventilation, you know, must be. So, that documentation on a flow sheet or in a note would be acceptable to establish organ dysfunction. Then, whether it's on a flow sheet or in a note, you would determine if there's a start time for the mechanical ventilation or use the earliest time that's directly associated with the mechanical ventilation being on the patient.

Donna Bullock: Thanks, Noel. Here's another question for slide 21. What if the respiratory flow sheet shows "intubated" and shows vent settings are documented in the flow sheet at 1,600? Would 1,600 be used?

Noel Albritton: This is Noel again. OK. So, I'm just clarifying the question. There's a respiratory flow sheet.

Donna Bullock: Yeah, I'll just read it again just in case.

Noel Albritton OK. Thank you.

Donna Bullock: OK. All right. What if the respiratory flow sheet shows "intubated" and shows vent settings are documented in the flow sheet at 1600? Would 1600 be used?

Noel Albritton Thank you. No, based on that documentation, no, you would not use 1600 for the mechanical ventilation because the question is only referring to "intubated" and the vent settings being documented at 1600. You wouldn't use either of those to meet the organ dysfunction criteria. Criteria C, organ dysfunction, is looking for when the patient was started on the actual ventilator, if they were intubated. If there's not a start time for that, use the earliest time directly associated with the patient being on the ventilator. So, you would disregard documentation of intubation, documentation of just the vent settings, and only use that documentation that refers to the patient being started on the vent or patient being on the vent.

Donna Bullock: OK. I have two questions now for slide 26. OK. This is the first one. On slide 26, it's not clear if initial lactic result would be obtained in OR, interventional radiology, etc.

Noel Albritton: OK. This is Noel again. So, the updated guidance on slide 26 is referring to the *Initial Lactate Level Result* data element. By the time you reach the *Initial Lactate Level Result* data element in the algorithm, you've already abstracted the *Initial Lactate Level Collection* data element as well as the date and time for the initial lactate level. So the *Initial Lactate Level Result* data element, when you get to that point, if that collection of the initial lactate was in the OR, interventional radiology, during CPR, or during procedural or conscious sedation, you would select Value 1 at the *Initial Lactate Level Result* data element, and that result would not be used to determine if a repeat lactate was necessary. Then, the initial lactate-level result would not be used to establish septic shock. So, that's why you would select Value 1 at that data element.

Donna Bullock: OK. This question is also related to slide 26, and I'm not sure if this overlaps. On slide 26, you indicated to select Value 1 (Yes) if the initial lactate was obtained in the OR/IR during a code or conscious sedation.

However, you went on to say to not use this Value 2 (No) would be selected and not Value 1 (Yes) on this slide. Was this an error on the slide? Can we read that one again?

Noel Albritton: No, I think you have the right slide here. Slide 26, it's like you mentioned. It's also talking about selecting Value 1 for the *Initial Lactate Level Result*. I don't recall talking about selecting Value 2 (No) for that particular slide. In either case, if the initial lactate level collection occurred in the OR, interventional radiology, during a code, or procedural or conscious sedation, like we mentioned, you would select Value 1 for the *Initial Lactate Level Result* data element. If there's further questions about that, feel free to submit them through the through the QualityNet online Q&A tool, and we will help you.

Donna Bullock: Thanks, Noel. OK. This one doesn't have a slide number. "1600 in triage, the EDRN documents chief complaint, family thinks patient has UTI. The EDMD documents suspect infection time 1753." Which time would you use to meet the infection portion of the element?

Noel Albritton: All right. Thank you. This is a good question that we see fairly often. So, at 1600, there's an ED triage nurse note that includes, "Family thinks patient has a UTI." For purposes of establishing criteria A for *Severe Sepsis*, this is acceptable nursing documentation of an infection or of a possible or suspected infection. Then, also the MD documentation of a suspected infection at 1753 would also be acceptable for meeting criteria A, infection. When you have multiple documentation of infections, you would use the earliest time that all three clinical criteria are met.

So, if SIRS criteria and organ dysfunction criteria are met within six hours of 1600, the nursing documentation of the UTI, then that nursing documentation of the infection would be acceptable for establishing the *Severe Sepsis* clinical criteria. If SIRS criteria and organ dysfunction were met later and they were within six hours of the MD documentation of the suspected infection, then you would use that later infection time.

So, the goal is that you may have multiple documentation of infection, but you're looking for the time all three clinical criteria were met the earliest.

Donna Bullock: OK. Thank you. Our next question is: In instances where a patient is seen at a remote location of the hospital, for example the ED, and is transferred to the main hospital, would you say Yes as transfer from hospital?

Noel Albritton: OK. So, the question refers to a remote location of the hospital, such as an ED, and then being transferred to the main hospital. By remote location, that generally, from what we've seen in the questions that come in from abstractors, refers to a satellite ED that's not connected to the main hospital. So, in that case, when the patient is at a remote satellite ED that's not connected, not part of the main hospital location, and they are transferred from that ED to the main hospital, you would select Yes for the transfer data element. If the ED was connected to the main hospital and they move from the ED into a floor unit of the main hospital, then you would select No for the transfer data element.

Donna Bullock: Thank you, Noel. Our next question is: In the question where patient arrived from outside ED in private vehicle, abstract Yes to transfer. Does the timing of transfer impact this? If the patient was told to present to the ED and arrived six hours later, is this still abstracted Yes to transfer?

Noel Albritton: So, this is another good question. For abstraction purposes of the transfer data element, the timing, as far as when the patient left in their private vehicle to transfer to the next facility, that time period, would not necessarily be relevant when you're determining which value to select for the transfer data element. The more important thing for abstraction purposes is that there's documentation in the medical record that the patient was a transfer patient and received as a transfer to the second facility.

Donna Bullock: OK. Thank you. We're running out of time, but I think we have enough time for just a couple more questions, maybe one, depending on how long the answer is.

For crystalloid fluids, there are two orders for one liter each with comments, CKD. Patient weights 80 kilograms, so needs 2,400 milliliters for 30 milliliters per kilogram. To clarify, would I use two liters based on the two orders with CKD as the reason?

Noel Albritton: So, this is Noel again. In this question, there are two orders for lesser volumes, 1,000 milliliters each, and both contain a comment that has a reason for each of those 1 ,000 milliliter volumes. So, in this scenario, you would combine the two lesser volumes. Assuming they were ordered within the specified timeframe for the *Crystalline Fluid Administration* data element, you would combine the two lesser volumes because each has its own reason for each of those lesser volumes. Then, you would use the two liters as the target volume rather than the 30 milliliters per kilogram volume.

Donna Bullock: OK. This is the last one. When ascertaining lesser fluid totals, what if there are no provider comments in the order itself? Is it acceptable to just use the documented amounts along with the note in the provider's notes as to the reason for the lesser fluids?

Noel Albritton: This is another good question. The abstraction guidance for using lesser volume as the target volume requires that the lesser volume be ordered, but it also requires physician/APN/PA documentation that includes the lesser volume and the reason within the same source documentation. So, if you have lesser volume that is just in an order, and then you need to go to the physician notes to look for a reason for the lesser volume, then you would not use the lesser volume that's ordered as the target volume in that case because the reason is not documented with the lesser volume. If you had the order for a lesser volume and then, within physician/APN/PA notes, there was documentation that included the lesser volume and reason, then, of course, it's acceptable to use that lesser volume as the target volume.

Donna Bullock: All right. Thank you, Noel. That is all the time we have questions for today. Next slide, please.

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