Guidelines for Using Release Notes
The Release Notes provides modifications to the Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.5. The information in this document is to be used as a reference and is not intended to be used to program abstraction tools. Please refer to the Specifications Manual for National Hospital Inpatient Quality Measures for the complete and current technical specifications and abstraction information.

The notes are organized to follow the order of the Table of Contents. The implementation date is 01/01/2019, unless otherwise specified. The headings are described below:

- **Impacts** - used to identify the impacted measures and portion(s) of the Manual Section, e.g., Alphabetical Data Dictionary, Measure Information Form (MIF) and Flowchart (Algorithm).

- **Description of Changes** - used to identify the section within the document where the change occurs, e.g., Definition, Data Collection Question, Allowable Values, and Denominator Statement - Data Elements.

- **Rationale** - provided for the change being made.

Data elements that cross multiple measures and contain the same changes will be consolidated.

**NOTE**: In addition to being called out specifically in the Release Notes document, additions are yellow highlighted in the corresponding documents. The changes in the Hospital Initial Patient Population and Clinical Data XML File Layouts have yellow highlighted cells with actual changes noted in bold font.
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Note: click on any section title in the Release Notes to return to Table of Contents page.

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The content below is organized to follow the Table of Contents in the specifications manual.

Table of Contents (no updates)

Acknowledgement (no updates)

Introduction
Impacts:  
All Sections

Rationale: An update is being made to reflect the current CMS and Joint Commission quality initiatives related to the inpatient specifications manual.

Description of Changes:
Change Introduction section throughout. Refer to manual for content edits.

Using the Specifications Manual for National Hospital Inpatient Quality Measures (no updates)

SECTION 1 – Data Dictionary

Introduction to Data Dictionary

Impacts:  
Medical Record Documentation

Rationale: An update is being made to reflect current manual specifications.

Description of Changes:
Change under fifth paragraph, second bullet point:
ICU Admission or Transfer Date
To:
Septic Shock Presentation Date

Impacts:  
Diagnostic/Laboratory Tests

Rationale: An update is being made to reflect current manual specifications.

Description of Changes:
Change in second bullet point:
Lipid profile
To:
Lactate Level

Alphabetical Data Dictionary

Impacts:  
Administrative Contraindication to Care, Septic Shock

Rationale: The data element is being updated to provide additional guidance to the abstractor.

Description of Changes:
Notes for Abstraction
Add new fifth and sixth bullet points:
• An authorized patient advocate is someone (defined by facility policy) who is authorized to make decisions on behalf of the patient when the patient is not able to.
• If there is a signed AMA form or documentation by a physician/APN/PA or nurse indicating the patient left AMA prior to or within 6 hours following presentation of septic shock, select Value "1."
  o Explicit "left against medical advice" documentation is not required.
  Example:
  “Patient is refusing to stay for continued care” select Value “1.”
  o Documentation suggesting that the patient left before discharge instructions could be given does not count as leaving against medical advice.
  o An AMA form signed by the patient is not required, for the purposes of this data element.
  o Do not consider AMA documentation and other disposition documentation as “contradictory.” If any source states the patient left against medical advice, select Value “1,” regardless of whether the AMA documentation was written last.
  Example:
  AMA form signed and discharge instruction sheet states “Discharged home with belongings” select Value “1.”

Impacts:
Administrative Contraindication to Care, Severe Sepsis

Rationale: The data element is being updated to provide additional guidance to the abstractor.

Description of Changes:
Notes for Abstraction

Add fifth and sixth bullet points:
• An authorized patient advocate is someone (defined by facility policy) who is authorized to make decisions on behalf of the patient when the patient is not able to.

• If there is a signed AMA form or documentation by a physician/APN/PA or nurse indicating the patient left AMA prior to or within 6 hours following presentation of severe sepsis, select Value "1."
  o Explicit "left against medical advice" documentation is not required.
  Example:
  “Patient is refusing to stay for continued care” select Value “1.”
  o Documentation suggesting that the patient left before discharge instructions could be given does not count as leaving against medical advice.
  o An AMA form signed by the patient is not required, for the purposes of this data element.
  o Do not consider AMA documentation and other disposition documentation as “contradictory.” If any source states the patient left against medical advice, select Value “1,” regardless of whether the AMA documentation was written last.
  Example:
  AMA form signed and discharge instruction sheet states “Discharged home with belongings” select Value “1.”
Impacts:
Alcohol Use Status

Rationale: The data element is being updated to provide clarification for abstraction of screening for alcohol use status utilizing a validated screening tool.

Description of Changes:
Notes for Abstraction
Add under fifth bullet point:
EXCEPTION: If there is documentation of a validated questionnaire for alcohol screening completed within the first day of admission, select the appropriate Value 1 or 2 regardless of conflicting documentation.

Impacts:
Alcohol Use Status

Rationale: The data element is being updated to provide clarification for abstraction of cognitive impairment.

Description of Changes:
Notes for Abstraction
Remove eighth bullet point:
• If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication), Value “7” cannot be selected.

Remove tenth bullet point:
• If there is documentation that the patient was intubated on the day of admission (Day 0) and remains intubated through the entire first day (Day 1), select allowable Value “7” as the patient is unable to answer.

Change sub-bullets under twelfth bullet point to:
Examples of cognitive impairment include:
  o Altered Level of Consciousness (LOC)
  o Altered Mental Status
  o Cognitive impairment
  o Cognitively impaired
  o Cognitive impairment due to acute substance use, overdose, acute intoxication
  o Confused
  o Dementia
  o Intubation
  o Memory loss
  o Mentally handicapped
  o Obtunded
  o Psychotic/psychosis with documented symptoms
  o Sedation
Impacts:
**Blood Culture Collection Acceptable Delay**

**Rationale:** The data element is being updated to reduce abstractor burden and provide clarity.

**Description of Changes:**

**Notes for Abstraction**

**Change to:**

- **Only** the following situations demonstrate an acceptable delay where the blood culture was drawn after the *Broad Spectrum or Other Antibiotic Administration Date and Time.* If there is an acceptable delay, choose Value “1.”
  - Surgical patients who receive a pre-op or post-op prophylactic antibiotic within 24 hours before severe sepsis was identified and had a blood culture drawn after the prophylactic antibiotic was started.
  - Antibiotics were started in the hospital for an infection within 24 hours before severe sepsis was identified, and a blood culture was drawn sometime after the antibiotic dose was started.
  - Antibiotics were started prior to hospital arrival within 24 hours before severe sepsis was identified, and a blood culture was drawn after the pre-hospital antibiotics were started.
  - A physician/APN/PA documented reason for the delay, which makes it clear that waiting to start the antibiotic would be detrimental to the patient.

**Examples:**

- ED Physician Note: Patient condition worsening, IV Vanco ordered stat, blood and urine cultures ordered, awaiting CXR.
- Hospitalist Progress Note: Patient’s deteriorating condition concern for rapidly advancing infection, starting IV antibiotics now, lab on way to collect blood cultures.
- Obstetric patients given prophylactic antibiotics for ruptured membranes, group B strep, or prior to a caesarean section.
  - If there is no documentation supporting an acceptable delay in the collection of a blood culture, choose Value “2.”

**Exclusion Guidelines for Abstraction**

**Change to:**

Oral (PO) Antibiotics

**Impacts:**

*Broad Spectrum or Other Antibiotic Administration*

**Rationale:** The data element is being updated to reduce abstractor burden and provide clarity.

**Description of Changes:**

**Notes for abstraction**

**Remove** sixth bullet point:

- Do not collect antibiotics documented on an operative report unless the surgeon states that the surgeon actually administered the dose.
Change ninth bullet point to:

- Do not abstract antibiotics from sources that do not represent actual administration.
  
  **Examples** that **do not** represent actual administration:
  
  - Pre-Op Checklist states:
    - IV Started at 1730
    - Preop Antibiotic Given at 1800
  - Operative report states:
    - IV antibiotics were given prior to procedure
    - IV antibiotics given at 0900 prior to incision

**Impacts:**

**Crystalloid Fluid Administration**

**Rationale:** The data element is being updated to provide additional guidance to the abstractor.

**Description of Changes:**

**Definition**

**Change to:**

Documentation of initiation of crystalloid fluids within the specified time frame AND complete infusion of the target ordered volume.

**Suggested Data Collection Question**

**Change from:**

Were crystalloid fluids inititated prior to, at the time of, or after the presentation of Initial Hypotension, Initial Lactate Level Result >=4 mmol/L, or physician/APN/PA Documentation of Septic Shock?

**Change to:**

Were crystalloid fluids initiated within the specified time frame AND completely infused based on the target ordered volume?

**Allowable Values**

**Change from:**

1 (Yes) Target ordered volume of crystalloid fluids were ordered initiated, and infused prior to, at the time of, or after the presentation of Initial Hypotension, Initial Lactate Level Result >=4 mmol/L, or Documentation of Septic Shock.

2 (No) Less than the target ordered volume of crystalloid fluids were ordered initiated, or infused prior to, at the time of, or after the presentation of Initial Hypotension, Initial Lactate Level Result >=4 mmol/L, or Documentation of Septic Shock, or unable to determine volume ordered.

3 (No) Crystalloid fluids were not initiated prior to, at the time of, or after the presentation of Initial Hypotension, Initial Lactate Level Result >=4 mmol/L, or Documentation of Septic Shock, or unable to determine whether or not they were administered.

4 (No) There is documentation the patient has an implanted Ventricular Assist Device (VAD) or documentation of the patient or authorized patient advocate refusal of IV fluids.

**Change to:**

1 (Yes) Target volume of crystalloid fluids were ordered AND initiated within the specified time frame. Additionally, the target ordered volume was completely infused.
2 (No) Less than the target volume of crystalloid fluids were ordered OR initiated within the specified time frame. The target ordered volume was not completely infused.

3 (No) The target volume of crystalloid fluids was NOT initiated within the specified time frame.

4 (No) There is documentation the patient has an implanted Ventricular Assist Device (VAD) OR documentation of the patient or authorized patient advocate refusal of IV fluids.

Notes for Abstraction

Change to:

- The specified time frame for abstraction of crystalloid fluids is within 6 hours prior through 3 hours after either of the following trigger events. If both are present the specified time frame is determined by the earliest trigger.
  - Initial Hypotension Date and Time
  - Septic Shock Presentation Date and Time
- The target ordered volume must be ordered and initiated within the specified time frame if Initial Hypotension or Septic Shock is present. Additionally, in order to choose Value “1”, the target ordered volume must be documented as completely infused. The target ordered volume is NOT required to be completely infused within the specified time frame. If the target ordered volume is not completely infused, choose Value “2.”
- Crystalloid fluid volumes ordered that are equivalent to 30 mL/kg or within 10% less than 30 mL/kg are considered the target ordered volume.

Example:
2000 mL of normal saline was ordered and initiated in the ED. The patient’s weight is not available or documented at the time of the order. After admission to critical care a weight is obtained of 74 kg. Based on this weight 30 mL/kg is 2220 mL. The 2000 mL ordered is within 10% lower of 2220 mL (2220 mL – 222 mL = 1998 mL) and is an acceptable volume.

- To determine the target ordered volume:
  - Use the patient weight in kilograms (kg) if documented.
  - If not documented, divide the weight in pounds by 2.2; that yields the weight in kg. Round the weight to the nearest whole number.
  - Multiply the weight in kg by 30; the result is the number of mL of IV fluid that should be specified in the physician/APN/PA order(s).
  - Round the volume of IV fluid (mL) to the nearest whole number.

Examples:
- Patient weight is 160 pounds. 160/2.2 = 72.72 kg. Round to 73 kg. 73 x 30 = 2190 (mL). Physician order is “Infuse 2400 mL 0.9% Normal Saline over the next two hours.” This is acceptable because 2400 mL is greater than 2190.
- Patient weight is 160 pounds. 160/2.2 = 72.72 kg. Round to 73 kg. 73 x 30 = 2190 (mL). Physician order is “Give 1000 mL Lactated Ringers over the next 4 hours.” This is not acceptable because 1000 mL is less than 2190.

- To calculate the appropriate target ordered volume use the actual or estimated weight in the following priority order.
  1. Weight documented in the crystalloid fluid order
2. Weight documented closest and prior to the order for crystalloid fluids
3. Weight documented closest and after the order for crystalloid fluids

- Physician/APN/PA can use Ideal Body Weight (IBW) to determine the target ordered volume if all of the following conditions are met:
  - Physician/APN/PA documents the patient is obese (defined BMI >30).
  - Physician/APN/PA documents IBW is used to determine target ordered volume.
  - IBW must be present in the medical record, abstractors should not calculate the IBW.

- Other acceptable weight terms include predicted weight, dosing weight, and adjusted body weight.

- If the total volume of crystalloid fluids ordered is less than the target ordered volume, select Value “2.”

- If there is documentation the infusion was stopped prior to reaching the target ordered volume, select Value “2.”

- Documentation of fluid initiation:
  - Medical record documentation must be clear that crystalloid fluids were actually initiated (i.e., date and time of administration is noted).
  - Do not use physician/APN/PA orders as equivalent to actual initiation of fluids as they are not specific to initiation.

- Crystalloid fluid orders:
  - Physician/APN/PA orders are required for the fluids.
  - The order must include the type of fluid, the volume of fluid, and a rate or time over which the fluids are to be given.
  - The terms bolus, wide-open, or open are acceptable for a rate or infusion duration.
  - If the type of fluid, volume of fluid, rate or infusion duration is missing, do not use the order toward the target ordered volume.
  - The target ordered volume may be in a single order or a series of multiple orders.
  - If crystalloid fluids are initiated via multiple physician/APN/PA orders, only abstract crystalloid fluids initiated within the specified time frame.

- **Exception for Prior to Arrival:** Documentation of crystalloid fluids administered prior to arrival to the hospital (e.g., ambulance, nursing home) that are part of the medical record are acceptable if the documentation of fluid administration contains the type, volume, start time, and either a rate, duration, or end time of the fluid infusion. A physician/APN/PA order for fluids administered prior to arrival is not required.

- **Exception for Operating Room (OR):** Crystalloid fluids administered in the OR by a physician/APN/PA are acceptable without an order if a fluid type, an infusion start time, and an infusion rate or infusion end time is documented.

- To determine if the target ordered volume was completely infused, one of the following must be documented along with the infusion start time. If one of the following is not documented, do not use the fluids toward the target ordered volume:
  - An infusion rate
  - Infusion duration or time over which to infuse
  - Infusion end or completion time

**Examples:**
- Order for 1500 mL (30 mL/kg) of normal saline over 1 hour started at 08:00. There is no infusion end time documented, and no documentation
indicating the 1500 mL was not infused. The infusion end time can be determined based on the duration in the order. Select Value “1.”

- Order for 1000 mL (30 mL/kg) normal saline bolus started at 09:30. The nurse documented an infusion rate of 1000 mL/hour. There is no fluid bolus end time documented, and no documentation indicating the 1000 mL was not infused. The infusion end time can be determined based on the rate. Select Value “1.”
- Order for 2000 mL (30 mL/kg) normal saline bolus started at 08:30. There is no infusion rate documented and no fluid bolus end time documented. An infusion end time cannot be determined. Choose Value “2.”

- If a rate or duration to infuse fluids contained within the order is different from the rate or duration the fluids were actually administered, use the rate or duration the fluids were actually administered over.

**Example:**
- Fluid Order: 0.9% NS 1000 mL bolus at 150 mL/hr
- Nurse documents a start time of 1500 and end time of 1800 for the 1000 mL bolus
- Use the start and stop time documented by nursing that reflects the duration over which the fluids were actually administered.

- Only those crystalloid fluids given at a rate greater than 125 mL/hour should be used towards the target ordered volume. Do not use crystalloid fluids given at 125 mL/hr or less toward the target ordered volume.
- Acceptable fluids are crystalloid or balanced crystalloid solutions.
- Crystalloid fluids or balanced crystalloid fluids that are given to dilute medications are acceptable to count towards the target ordered volume.
- Crystalloid fluid volumes to which the following electrolytes have been added may be counted toward the target ordered volume requirement: potassium, magnesium, calcium, lactate, acetate, or gluconate.
- Only abstract fluids administered through the intravenous or intraosseous route.
- If there is documentation that the patient has an implanted ventricular assist device (VAD) prior to or at the time of identifying need for crystalloid fluids, choose Value “4” regardless of the volume and rate of crystalloid fluids ordered.
- Physician/APN/PA or nursing documentation indicating patient or authorized patient advocate has refused IV fluid administration prior to or within 6 hours following presentation of septic shock can be used to select Value “4.”

**Impacts:**

**Decision to Admit Date**

**Rationale:** The data element is being updated with new guidance.

**Description of Changes:**

**Notes for Abstraction**

**Change to:**

- If the date of the decision to admit to observation or inpatient status is unable to be determined from medical record documentation, select “UTD.”
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the
parameters of care [after the *Discharge Date*] **and** no other documentation is found that provides this information, the abstractor should select “UTD.”

**Examples:**
- Documentation indicates the *Decision to Admit Date* was 03-42-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *Decision to Admit Date* is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *Decision to Admit Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Decision to Admit Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select “UTD.”

**Note:** Transmission of a case with an invalid date as described above will be rejected from the CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *Decision to Admit Date* allows the case to be accepted into the warehouse.

- When reviewing ED records do **NOT** include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports or ECGs) obtained prior to arrival. The intent is to utilize any documentation that reflects processes that occurred in the ED or hospital.
- For purposes of this data element, the source “Emergency Department record” includes any documentation from the time of ED arrival to the time the patient physically departed from the ED.

  **Example:**
  - ED departure is at 11:00 on 03-12-20xx. The attending physicians admit orders written in the inpatient record at 10:00 on 03-12-20xx are considered part of the ED record.
- Disregard physician/APN/PA narrative documentation of a consult or orders for consult, transfer to another physician’s service, or discussion with another physician since this does not reflect a decision was made.
- If there is more than one date of documentation for the decision to admit, use the following order to determine which date to abstract.
  1. Specified date the decision to admit was documented.
  2. Specified date the decision to admit was documented in a non-narrative location (e.g., flowsheet, checklist, screening).
  3. Note opened date for the decision to admit documented in a non-narrative location without a specified date (e.g., flowsheet, checklist, screening).
  4. Note opened date for narrative documentation identifying the decision to admit was made without a specified date.
- *Decision to Admit Date* includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery.

  **Example:**
  - The ED physician documents that he/she is sending the patient to the OR for surgery. The decision to admit to observation or inpatient status date will abstract as the date this was documented.
• Use the date from the earliest documentation of decision to admit for either observation or inpatient.
   
   **Example:**
   The physician ordered “Admit Observation Service.” Four hours later the physician wrote an order to admit the patient to inpatient status. These orders were written while the patient was still receiving care in the ED. Use the earlier order for Observation Services to abstract as date and time.

• If it can be determined that the patient arrived on the same date and departed on the same date, the arrival date can be used as the decision to admit to observation or inpatient status date.

• Data fields representing ‘decision to admit’ in electronic documentation for this specific episode of care are acceptable to use as long as they are the earliest physician/APN/PA documentation and clearly defined to capture the date an observation status or inpatient admit decision was documented. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge date being abstracted.

   **Examples:**
   - Decision to Admit
   - Dispo
   - Disposition set to admit

• For purposes of this data element *Decision to Admit Date* is the date on which the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital. This will not necessarily coincide with the date the patient is officially admitted to inpatient status.

• If the decision to admit the patient to observation or inpatient status is made, but the actual request for a bed is delayed until an inpatient bed is available, record the date the physician/APN/PA communicated the decision to admit.

• If the decision to admit to observation or inpatient status date is dated prior to the date of patient arrival or after the date of departure, select “UTD.”

• For documentation of a decision to admit accompanied by an indicator, the table below should be used. Documentation containing a positive indicator should be used for a decision to admit, documentation containing a negative indicator should **not** be used for a decision to admit.

<table>
<thead>
<tr>
<th>Positive Indicators</th>
<th>Negative Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan to admit</td>
<td>Request admission</td>
</tr>
<tr>
<td>Doctor accepts admission</td>
<td>May need admission</td>
</tr>
<tr>
<td>Plan to hospitalize</td>
<td>Doctor will accept patient</td>
</tr>
<tr>
<td>Admit to doctor</td>
<td>Recommend admission</td>
</tr>
<tr>
<td>Need to admit</td>
<td>Would like to admit</td>
</tr>
</tbody>
</table>
Impacts:
Decision to Admit Time

Rationale: The data element is being updated with new guidance.

Description of Changes:
Notes for Abstraction

Change to:
• For times that include “seconds,” remove the seconds and record the military time.
  
  Example:
  15:00:35 would be recorded as 15:00.

• If the time of the decision to admit to observation or inpatient status is unable to be determined from medical record documentation, select “UTD.”

• The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”

  Example:
  Documentation indicates the Decision to Admit Time was 3300. No other documentation in the list of ONLY Acceptable Sources provides a valid time. Since the Decision to Admit Time is outside of the range in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”

Note: Transmission of a case with an invalid time as described above will be rejected from the CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for Decision to Admit Time allows the case to be accepted into the warehouse.

• When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports, or ECGs) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.

• For purposes of this data element, the source “Emergency Department record” includes any documentation from the time of ED arrival to the time the patient physically departed from the ED.

  Example:
  ED departure is at 11:00 on 03-12-20XX. The attending physicians admit orders written in the inpatient record at 10:00 on 03-12-20XX are considered part of the ED record.

• Disregard physician/APN/PA narrative documentation of a consult or orders for consult, transfer to another physician’s service, or discussion with another physician since this does not reflect a decision was made.

  Examples that reflect a decision to admit was NOT made:
  o ED physician note states “Discussed case with hospitalist.” This is only documentation that a discussion occurred, there is no documentation regarding a decision to admit.
  o ED physician note states “Discussed patient with Dr. Jones who recommends admission.” This reflects a discussion occurred and a recommendation was made to admit but does not indicate a decision was made to admit.
ED physician note states “Contacted Dr. Smith for admission consult.” This reflects a consult has been requested for admission but does not indicate a decision to admit has been made.

ED physician note states “Possible admission pending cardiology consult.” This reflects a consult was ordered and admission is possible but does not indicate a decision to admit has been made.

**Examples** that reflect a decision to admit was made:

- ED physician note states “Discussed case with hospitalist on call, plan to admit.” The note references a discussion with another physician with “plan to admit” documented, indicating a decision to admit has been made.

- ED physician note states “Discussed case with Dr. Brown who will admit patient to ICU.” The note references a discussion with another physician with “who will admit patient” documented, indicating a decision to admit has been made.

- If there is more than one time of documentation for the decision to admit, use the following order to determine which time to abstract.
  1. Specified time the decision to admit was documented.
  2. Specified time the decision to admit was documented in a non-narrative location (e.g., flowsheet, checklist, screening).
  3. Note opened time for the decision to admit documented in a non-narrative location without a specified time (e.g., flowsheet, checklist, screening).
  4. Note opened time for narrative documentation identifying the decision to admit was made without a specified time.

- **Decision to Admit Time** includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery.

  **Example:**
  The ED physician documents that he/she is sending the patient to the OR for surgery. The decision to admit to observation or inpatient status time will abstract as the time this was documented.

- Use the time from the earliest documentation for either observation or inpatient.

  **Example:**
  The physician ordered “Admit Observation Services.” Four hours later the physician wrote an order to admit the patient to inpatient status. These orders were written while the patient was still receiving care in the ED. Use the earlier order for Observation Services to abstract decision to admit time.

- Data fields representing ‘decision to admit’ in electronic documentation for this specific episode of care are acceptable to use as long as they are the earliest physician/APN/PA documentation and clearly defined to capture the time an observation status or inpatient admit decision was documented. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge time being abstracted.

  **Examples:**
  - Decision to Admit
  - Dispo
  - Disposition set to admit

- For purposes of this data element “Decision to Admit Time” is the time the physician/APN/PA communicates the decision to admit the patient to observation or
inpatient status from the emergency department to the hospital. This will not necessarily coincide with the time the patient is officially admitted to inpatient status.

- If the decision to admit the patient to observation or inpatient status is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA communicated the decision to admit.

- If documentation of the decision to admit to observation or inpatient status time is prior to arrival or after departure from the ED, select, “UTD.”

  **Example:**
  The APN saw the patient in the clinic and sent him/her to the ED for admission. Select UTD.

- For documentation of a decision to admit accompanied by an indicator, the table below should be used. Documentation containing a positive indicator should be used for a decision to admit, documentation containing a negative indicator should **not** be used for a decision to admit.

<table>
<thead>
<tr>
<th>Positive Indicators</th>
<th>Negative Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan to admit</td>
<td>Request admission</td>
</tr>
<tr>
<td>Doctor accepts admission</td>
<td>May need admission</td>
</tr>
<tr>
<td>Plan to hospitalize</td>
<td>Doctor will accept patient</td>
</tr>
<tr>
<td>Admit to doctor</td>
<td>Recommend admission</td>
</tr>
<tr>
<td>Need to admit</td>
<td>Would like to admit</td>
</tr>
</tbody>
</table>

**Impacts:**

*Documentation of Septic Shock*

**Rationale:** To reduce abstraction burden, the data element is being removed in its entirety.

**Description of Changes:**

*Remove* in Index and Data Dictionary in its entirety:

*Documentation of Septic Shock*

**Impacts:**

*Influenza Vaccination Status*

**Rationale:** The *Influenza Vaccination Status* data element is being updated with new and clarifying guidance.

**Description of Changes:**

*Notes for Abstraction*

**Add** new sub-bullet point under first bullet point:
- Only influenza vaccines administered during August through March are acceptable.

**Add** new 11th, 12th, and 13th bullet points:

- If it is documented in the chart that the patient’s influenza vaccination status is “up to date” or “current,” select Allowable Value “2.” Documentation of “up to date” or “current” in the vaccination record that does not reference the influenza vaccine is not sufficient to select Allowable Value “2.”
• Documentation of the acronym “UTD,” even with specific reference to the influenza vaccine, is not sufficient to select Allowable Value “2.”
• Documentation from a pre-admission screening or previous episode of care indicating that the patient received the influenza vaccine with a date from the current season would be acceptable to choose Value “2.”

Remove last two bullet points:
• If it is documented in the chart that the patient’s influenza vaccination status is “up to date” or “current,” select Allowable Value “2.” Documentation of “up to date” or “current” in the vaccination record that does not reference the influenza vaccine is not sufficient to select Allowable Value “2.”
• Documentation of the acronym “UTD,” even with specific reference to the influenza vaccine, is not sufficient to select Allowable Value “2.”

Impacts:
Initial Hypotension

Rationale: The data element is being updated to provide additional guidance to the abstractor.

Description of Changes:
Definition
Change to:
Documentation of the presence of initial hypotension within the specified time frame and prior to the completion of the target ordered volume (30 mL/kg or up to 10% less than 30 mL/kg) of crystalloid fluids.

Suggested Data Collection Question
Change from:
Was initial hypotension present 6 hours prior to or within 6 hours following Severe Sepsis Presentation Date and Time?

Change to:
Was initial hypotension present within the specified time frame?

Allowable Values
Change from:
1 (Yes) Initial Hypotension was present 6 hours prior to or within 6 hours following Severe Sepsis presentation.
2 (No) Initial Hypotension was not present 6 hours prior to or within 6 hours following Severe Sepsis presentation or unable to determine from medical record documentation.

Change to:
1 (Yes) Initial Hypotension was present within the specified time frame.
2 (No) Initial Hypotension was not present within the specified time frame or unable to determine from medical record documentation.

Notes for Abstraction
Change to:
• The specified time frame for assessing Initial Hypotension is 6 hours prior to or within 6 hours following Severe Sepsis Presentation Date and Time.
• The criteria for determining that Initial Hypotension was present are as follows:
  o Two hypotensive blood pressure readings from measurements taken at different times within the specified time frame. The hypotensive blood pressure readings do not need to be consecutive but need to be within 3 hours of each other. Acceptable readings are:
    ▪ systolic blood pressures <90, or
    ▪ mean arterial pressures (MAP) <65 or
    ▪ a decrease in systolic blood pressure by >40 mm/Hg. Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection or severe sepsis and not other causes.
• Use the time the hypotensive blood pressures were taken or obtained. If time taken or obtained is not available, use recorded or documented time. Do not abstract hypotensive values from narrative charting unless there is no other documentation that reflects the time that the same hypotensive values were obtained.
• Hypotensive BPs obtained within the operating room (OR) should not be used.
• Hypotensive BPs documented from an orthostatic BP evaluation should not be used.
• For the following, physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time is required.
  o If hypotension (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it should not be used. Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation.
    ▪ Normal for that patient
    ▪ Is due to a chronic condition
    ▪ Is due to a medication
    Example: “Hypotensive after pain meds”
  o If a hypotensive value is due to an acute condition that has a non-infectious source/process, it should not be used (Refer to Severe Sepsis Present criteria “a” to determine if the source of the acute condition is an infection).
    Example: “BP 85/50 r/t blood loss” “2 liters lost via GI bleed” (blood loss is the acute condition and GI bleed is the non-infectious source).
  o If a hypotensive value should not be used based on the above guidance, all instances of less severe values should not be used.
    Example: “BP 80/50 secondary to Lasix” (systolic blood pressures ≥ 80 would not be used).
  o If a hypotensive value is due to the following, the criteria value should be used.
    ▪ Acute condition
      Example: Progress Note: “Hypotension r/t dehydration.”
    ▪ Acute on chronic condition
      Example: H&P: “Hypotension due to acute exacerbation of chronic heart failure.”
- **Infection**

  **Example:**
  Physician Note: “Sepsis, hypotensive.”

- Documentation of a term that represents or is defined by an SBP <90 mmHg or MAP <65 mmHg is acceptable in place of an abnormal value.

  **Example:**
  Hypotension (Systolic blood pressure <90 mmHg).

- If within the same physician/APN/PA documentation, there is conflicting documentation indicating hypotension is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, the criteria value **should be used**.

  **Example:**
  “Hypotensive post medications, possibly r/t sepsis.”

- If within 24 hours after **Severe Sepsis Presentation Time** there is conflicting information within **two or more separate** pieces of physician/APN/PA documentation indicating hypotension is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, abstract based on the latest piece of documentation within the 24-hour period.

  **Example:**
  - Note 1200: “Antihypertensive discontinued due to hypotension.”
    Note 1600: “Sepsis with hypotension and SIRS criteria.”
    - Hypotensive readings should be used.

- Initial hypotension is hypotension that is present prior to the target ordered volume of crystalloid fluids being completely infused.

- If hypotension was present within 6 hours prior to or within 6 hours following **Severe Sepsis Presentation Date and Time**, select Value “1.”

- If hypotension was not present within 6 hours prior to or within 6 hours following **Severe Sepsis Presentation Date and Time**, select Value “2.”

- If within 24 hours of the **Severe Sepsis Presentation Time** there is physician/APN/PA or nursing documentation indicating a hypotensive reading is invalid, erroneous or questionable, disregard that reading when determining the presence of Initial Hypotension.

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

  **Example:**
  - Progress note: “Not hypotensive in ED.”
    - Hypotensive values in ED should not be used.

- Use of documentation in pre-hospital records (e.g., ambulance records, nursing home records) that is considered part of the medical record is acceptable for determining Initial Hypotension.
Impacts:
Initial Lactate Level Collection

Rationale: The data element is being updated to reduce abstractor burden and provide clarity.

Description of Changes:
Definition
Change to:
Documentation of collection of an initial lactate level within the specified time frame.

Suggested Data Collection Question
Change from:
Was an initial lactate level drawn between 6 hours prior to and 3 hours following the presentation of severe sepsis?
To:
Was an initial lactate level drawn within the specified time frame?

Allowable Values
Change from:
1 (Yes) An initial lactate level was drawn in the time window between 6 hours prior to and 3 hours following the presentation of severe sepsis.
2 (No) An initial lactate level was not drawn in the time window between 6 hours prior to and 3 hours following the presentation of severe sepsis, or unable to determine.

To:
1 (Yes) An initial lactate level was drawn within the specified time frame.
2 (No) An initial lactate level was not drawn within the specified time frame, or unable to determine.

Notes for Abstraction
Remove:
- If there are multiple lactate levels, only abstract the level drawn closest to the time of presentation of severe sepsis. If there is a lactate level both before and after presentation of severe sepsis that are the same time apart, use the level prior to presentation. That lactate level is the initial lactate level for purposes of this data element.

Add new first and second bullet points:
- The specified time frame within which an initial lactate must be drawn is within 6 hours prior through 3 hours following severe sepsis presentation.
  - If multiple lactate levels are drawn within the specified time frame, use the lactate drawn PRIOR to the Severe Sepsis Presentation Time with the HIGHEST level.
  - If multiple lactate levels are drawn ONLY in the 3 hours after the Severe Sepsis Presentation Time, use the lactate drawn with the HIGHEST level within this time frame.
- If there is more than one time of documentation for the Initial Lactate Level Collection, use the following order to determine which time to abstract.
  1. Laboratory documentation indicating date and time lactate was drawn.
  2. Date and Time the lactate is documented as drawn in a non-narrative location (e.g., sepsis flowsheet, checklist, screening).
  3. Narrative note indicating lactate is drawn with an associated date and time.
Change from seventh bullet point to third bullet point:

- If there is no documentation indicating a lactate was drawn or collected, but there is supportive documentation that a lactate was drawn, use the earliest supportive documentation (e.g., lactate sent to lab, lactate received, lactate result).

Impacts:

**Initial Lactate Level Date**

**Rationale:** The data element is being updated to reduce abstractor burden and provide clarity.

**Description of Changes:**

**Notes for Abstraction**

**Remove:**

- If there are multiple lactate levels, only abstract the level drawn closest to the time of presentation of severe sepsis. If there is a lactate level both before and after presentation of severe sepsis that are the same time apart, use the level prior to presentation. That lactate level is the initial lactate level for purposes of this data element.

**Add** new first bullet point:

- If there is more than one date of documentation for the **Initial Lactate Level Collection**, use the following order to determine which date to abstract.
  1. Laboratory documentation indicating date lactate was drawn.
  2. Non-narrative location indicating lactate was drawn with an associated date (e.g., sepsis flowsheet, checklist, screening).
  3. Narrative note indicating lactate is drawn with an associated date.

Change from fourth bullet point to second bullet point:

- If there is not a lactate draw or collected date documented, but there is supportive documentation that a lactate was drawn, use the date of the earliest supportive documentation (e.g., lactate sent to lab, lactate received date, lactate result date).

Impacts:

**Initial Lactate Level Time**

**Rationale:** The data element is being updated to reduce abstractor burden and provide clarity.

**Description of Changes:**

**Notes for Abstraction**

**Remove:**

- If there are multiple lactate levels, only abstract the level drawn closest to the time of presentation of severe sepsis. If there is a lactate level both before and after presentation of severe sepsis that are the same time apart, use the level prior to presentation. That lactate level is the initial lactate level for purposes of this data element.

**Add** new first bullet point:

- If there is more than one time of documentation for the **Initial Lactate Level Collection**, use the following order to determine which time to abstract.
  1. Laboratory documentation indicating time lactate was drawn.
  2. Non-narrative location indicating lactate was drawn with an associated time (e.g., sepsis flowsheet, checklist, screening).
  3. Narrative note indicating lactate is drawn with an associated time.
Change from fourth bullet point to second bullet point:

- If there is not a lactate draw or collected time documented, but there is supportive
documentation that a lactate was drawn, use the time of the earliest supportive
documentation (e.g., lactate sent to lab, lactate received time, lactate result time).

Impacts:
Persistent Hypotension

Rationale: The data element is being updated to provide additional guidance to the abstractor.

Description of Changes:
Notes for Abstraction

Change to:

- The criteria for determining that persistent hypotension or new onset of hypotension
was present are as follows:
  - In the one hour following conclusion of administration of the target ordered
  volume of crystalloid fluids, two consecutive documented blood pressure
  readings of either:
    - systolic blood pressure <90, or
    - mean arterial pressure (MAP) <65 or
    - a decrease in systolic blood pressure by >40 mm/Hg. Physician/APN/PA
documentation must be present in the medical record indicating a >40
  mmHg decrease in SBP has occurred and is related to infection, severe
  sepsis or septic shock and not other causes.
  - Use the time the hypotensive blood pressures were taken or obtained. If time taken or
  obtained is not available, use recorded or documented time. Do not abstract
  hypotensive values from narrative charting unless there is no other documentation that
  reflects the time that the same hypotensive values were obtained.
  - Hypotensive BPs obtained within the operating room (OR) should not be used.
  - Hypotensive BPs documented from an orthostatic BP evaluation should not be used.
  - Determining presence of persistent hypotension (low is SBP <90 or MAP <65):
    - If there were no blood pressures or only one blood pressure recorded within the
      hour:
      - If the only blood pressure within the hour is normal, select Value “2.”
      - If there is no blood pressure or the only blood pressure within the hour is
        low, select Value “3.”
    - If there are more than two blood pressures documented, refer to the last two
      consecutive blood pressures within the hour:
      - If there is a normal blood pressure followed by another normal blood
        pressure, select Value “2.”
      - If there is a normal blood pressure followed by a low blood pressure,
        select Value “3.”
      - If there is a low blood pressure followed by a normal blood pressure,
        select Value “2.”
      - If there is a low blood pressure followed by another low blood pressure,
        select Value “1.”

- For the following, physician/APN/PA documentation prior to or within 24 hours after
  Severe Sepsis Presentation Time is required.
If hypotension (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it **should not be used**. Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation.

- Normal for that patient
- Is due to a chronic condition
- Is due to a medication

  **Example:**
  
  “Hypotensive after pain meds.”

If a hypotensive value is due to an acute condition that has a non-infectious source/process, it **should not be used** (Refer to *Severe Sepsis Present* criteria “a” to determine if the source of the acute condition is an infection).

  **Example:**
  
  “BP 85/50 r/t blood loss” “2 liters lost via GI bleed” (blood loss is the acute condition and GI bleed is the non-infectious source.

If a hypotensive value should not be used based on the above guidance, all instances of less severe values **should not be used**.

  **Example:**
  
  “BP 80/50 secondary to Lasix” (systolic blood pressures ≥ 80 would not be used).

If a hypotensive value is due to the following, the criteria value **should be used**.

- Acute condition

  **Example:**
  
  Progress Note: “Hypotension r/t dehydration.”

- Acute on chronic condition

  **Example:**
  
  H&P: “Hypotension due to acute exacerbation of chronic heart failure.”

- Infection

  **Example:**
  
  Physician Note: “Sepsis, hypotensive.”

Documentation of a term that represents or is defined by an SBP <90 mmHg or MAP <65 mmHg is acceptable in place of an abnormal value.

  **Example:**
  
  Hypotension (Systolic blood pressure <90 mmHg).

If within the same physician/APN/PA documentation, there is conflicting documentation indicating hypotension is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, the criteria value **should be used**.

  **Example:**
  
  “Hypotensive post medications, possibly r/t sepsis.”

If within 24 hours after *Severe Sepsis Presentation Time* there is conflicting information within **two or more separate** pieces of physician/APN/PA documentation indicating hypotension is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, abstract based on the latest piece of documentation within the 24-hour period.

  **Example:**
  
  Note 1200: “Antihypertensive discontinued due to hypotension.”
  
  Note 1600: “Sepsis with hypotension and SIRS criteria.”
Hypotensive readings should be used.

- Begin abstracting at the time the target ordered volume concludes; abstract for the time period that follows for the next hour only. Choose Value “1” if persistent hypotension or new onset of hypotension was present, choose Value “2” if persistent hypotension or new onset of hypotension was not present.

- If the completion time of the target ordered volume is documented in the medical record use that time as the start for the one hour within which to determine presence of persistent hypotension or new onset of hypotension.

- If the completion time of the target ordered volume is not documented in the medical record use the following criteria to determine the conclusion time.
  - If the order includes a time frame over which to infuse the crystalloid fluid, identify the time the fluids are started and add to that the duration identified in the order. This will represent the conclusion of crystalloid fluids.
    
    **Example:**
    An order for 1500 mL over 1 hour and the infusion is started at 10:00. Add 1 hour to the start time to determine infusion conclusion time of 11:00.

  - If the order includes a rate at which to infuse the crystalloid fluids, the end time can be calculated based on the volume, the rate and the start time.
    
    **Example:**
    An order for 1500 mL at 1000 mL/hour and the infusion is started at 10:00. The time over which 1500 mL is infused is the volume divided by the rate. 1500 mL divided by 1000 mL/hour is 1.5 hours. Add 1.5 hours to the start time to determine infusion conclusion time of 11:30.

  - If the order is for more than 30 mL/kg, 30 mL/kg will have been infused before the entire volume ordered is infused.
    
    **Example:**
    An order for 3000 mL over 2 hours, infusion started at 10:00. Patient weighs 80 kg, 30 mL/kg target volume is 2400 mL (as determined for Crystalloid Fluid Administration). Divide the total volume ordered by the infusion duration in minutes to determine the infusion rate (3000 mL/120 minutes = 25 mL/minute). Divide the 30 mL/kg target volume by the infusion rate to determine the number of minutes it takes to infuse the target volume (2400 mL/25 mL/min = 96 minutes). Add the number of minutes to infuse the target volume to the infusion start time to determine the time 30 mL/kg was completed (10:00 + 96 minutes = 11:36).

- If the order states “bolus” or “wide open” and does not include an infusion rate or time over which to infuse the fluids, an infusion rate recorded in the medical record by a nurse OR fluid bolus completed time or end time can be used to determine when the target ordered volume was completed.

  - Acceptable crystalloid fluids are identified in the Crystalloid Fluid Administration data element.

  - If the end time of the target ordered volume of crystalloid fluids cannot be determined, select Value “3.”

  - If crystalloid fluids were administered but at a volume less than the target ordered volume, choose Value “4.”

  - Use of documentation in pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record is acceptable for determining the presence of Persistent Hypotension.
• If within 24 hours of the *Severe Sepsis Presentation Time* there is physician/APN/PA or nursing documentation indicating a hypotensive reading is erroneous or questioning the validity of a hypotensive reading, disregard that reading for determining the presence of persistent or new onset of hypotension.

**Impacts:**

* Prescription for Alcohol or Drug Disorder Medication

**Rationale:** The data element is being updated to exclude cases where a prescription for alcohol or drug use disorder medication cannot be made because a patient is released to a court hearing and does not return or is discharged to jail/law enforcement.

**Description of Changes:**

**Allowable Values**

**Change** allowable value 3 from:
3. The patient’s residence is not in the USA

**To:**
3. The patient:
   - is being discharged to a residence outside the USA
   - is released to a court hearing and does not return
   - is being discharged to jail/law enforcement

**Impacts:**

* Prescription for Tobacco Cessation Medication

**Rationale:** The data element is being updated to exclude cases where a prescription for tobacco cessation medication cannot be made because a patient is released to a court hearing and does not return or is discharged to jail/law enforcement.

**Description of Changes:**

**Allowable Values**

**Change** allowable value from:
3. The patient’s residence is not in the USA

**To:**
3. The patient:
   - is being discharged to a residence outside the USA
   - is released to a court hearing and does not return
   - is being discharged to jail/law enforcement

**Impacts:**

* Referral for Addictions Treatment

**Rationale:** The data elements are being updated to exclude cases where a prescription for a referral for addictions treatment cannot be made because a patient is released to a court hearing and does not return or is discharged to jail/law enforcement.

**Description of Changes:**

**Allowable Values**

**Change** allowable value 4 from:
4. The patient’s residence is not in the USA
To:
4. The patient:
   - is being discharged to a residence outside the USA
   - is released to a court hearing and does not return
   - is being discharged to jail/law enforcement

**Impacts:**
*Referral for Addictions Treatment*

**Rationale:** The data element is being updated to provide abstraction guidance regarding conflicting documentation related to patient referrals for addictions treatment.

**Description of Changes:**
*Notes for Abstraction*

**Add** third bullet point:
- Select Value “5” if:
  - it cannot be determined that a referral for addictions treatment was made or;
  - it is unclear that the absence of the referral was due to a patient refusal or;
  - a referral was not offered.

**Impacts:**
*Referral for Addictions Treatment*

**Rationale:** The data element is being updated to provide clarification of the exclusion guidelines for abstraction related to self-help interventions.

**Description of Changes:**
*Exclusion Guidelines for Abstraction*

**Change** first bullet point to:
- Self-help interventions in the form of printed/electronic/digital media

**Impacts:**
*Referral for Outpatient Tobacco Cessation Counseling*

**Rationale:** The data element is being updated to exclude cases where a referral for outpatient tobacco cessation counseling cannot be made because a patient is released to a court hearing and does not return or is discharged to jail/law enforcement.

**Description of Changes:**
*Allowable Values*

**Change** allowable value 4 from:
4. The patient’s residence is not in the USA

**To:**
4. The patient:
   - is being discharged to a residence outside the USA
   - is released to a court hearing and does not return
   - is being discharged to jail/law enforcement
Impacts:
*Referral for Outpatient Tobacco Cessation Counseling*

**Rationale:** The data element is being updated to provide clarification of the exclusion guidelines for abstraction related to self-help interventions.

**Description of Changes:**
*Exclusion Guidelines for Abstraction*

**Change** third bullet point to:
- Self-help interventions in the form of printed/electronic/digital media

Impacts:
*Repeat Volume Status and Tissue Perfusion Assessment Performed*

**Rationale:** The data element is being updated to reduce abstractor burden and provide clarity.

**Description of Changes:**
*Notes for abstraction*

Under second bullet point, first sub-bullet point

**Add** new bullet point under examples:
- “I have reassessed the patient’s hemodynamic status”

Under second bullet point, second sub-bullet point

**Change** in first sentence, the word ‘seven’ to:
- eight

**Add** new sub-level bullet point:
- **Shock Index (SI)**
  - A shock index value documented in the medical record, or there is physician/APN/PA documentation that they have reviewed the shock index.

Impacts:
*Septic Shock Present*

**Rationale:** The data element is being updated to provide additional guidance to the abstractor.

**Description of Changes:**
*Allowable Values*

**Change** from:
- 1 (Yes) There is documentation of Septic Shock.
- 2 (No) There is no documentation of Septic Shock, or unable to determine.

**Change** to:
- 1 (Yes) Septic Shock is present.
- 2 (No) Septic Shock is not present, or unable to determine.
Impacts:
*Septic Shock Present*

Rationale: The data element is being updated to provide additional guidance to the abstractor.

Description of Changes:

Notes for Abstraction

Change to:

- Presence of Septic Shock may be identified based upon clinical criteria OR physician/APN/PA documentation of Septic Shock.
- If clinical criteria for Septic Shock are **NOT** met, but there is physician/APN/PA documentation of Septic Shock, choose Value “1.”
- In order to establish the presence of Septic Shock by clinical criteria, one of following two criteria (a or b) must be met:
  a. *Severe Sepsis Present*
     
     **Persistent Hypotension** in the hour after the conclusion of the target ordered volume of *Crystalloid Fluid Administration*, evidenced by two consecutive documented recordings of:
     - systolic blood pressure (SBP) <90, or
     - mean arterial pressure <65 or
     - a decrease in systolic blood pressure by >40 mmHg. Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, Severe Sepsis or Septic Shock and not other causes.
  b. *Severe Sepsis Present*
     
     Tissue hypoperfusion evidenced by
     - *Initial Lactate Level Result* is >=4 mmol/L

- For evaluation of blood pressure parameters to establish whether or not hypotension persists after crystalloid fluid administration, begin abstracting at the time that crystalloid fluid administration concludes (refer to the *Persistent Hypotension* data element); abstract for the time period that follows for the next hour only. Choose Value “1” if hypotension (systolic blood pressure <90 or mean arterial pressure <65 or a decrease in systolic blood pressure by >40 mmHg) was present in the hour after crystalloid fluid administration for two or more consecutive readings.
- Hypotensive BPs obtained within the operating room (OR) **should not be used**.
- Hypotensive BPs documented from an orthostatic BP evaluation **should not be used**.
- Use the time the hypotensive blood pressures were taken or obtained. If time taken or obtained is not available, use recorded or documented time. Do not abstract hypotensive values from narrative charting unless there is no other documentation that reflects the time that the same hypotensive values were obtained.
- For the following, physician/APN/PA documentation prior to or within 24 hours after *Severe Sepsis Presentation Time* **is required**.
  - If hypotension (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it **should not be used**. Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation.
    - Normal for that patient
    - Is due to a chronic condition
- Is due to a medication
  **Example:**
  "Hypotensive after pain meds"

  - If a hypotensive value is due to an acute condition that has a non-infectious source/process, it **should not be used** (Refer to *Severe Sepsis Present* criteria “a” to determine if the source of the acute condition is an infection).
    **Example:**
    "BP 85/50 r/t blood loss” “2 liters lost via GI bleed” (blood loss is the acute condition and GI bleed is the non-infectious source).

  - If a hypotensive value should not be used based on the above guidance, all instances of less severe values **should not be used**.
    **Example:**
    “BP 80/50 secondary to Lasix” (systolic blood pressures ≥ 80 would not be used).

- If a hypotensive value is due to the following, the criteria value **should be used**.
  - Acute condition
    **Example:**
    Progress Note: “Hypotension r/t dehydration.”

  - Acute on chronic condition
    **Example:**
    H&P: "Hypotension due to acute exacerbation of chronic heart failure."

  - Infection
    **Example:**
    Physician Note: “Sepsis, hypotensive.”

- Documentation of a term that represents or is defined by an SBP <90 mmHg or MAP <65 mmHg is acceptable in place of an abnormal value.
  **Example:**
  Hypotension (Systolic blood pressure <90 mmHg)

- If within the same physician/APN/PA documentation, there is conflicting documentation indicating hypotension is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, the criteria value **should be used**.
  **Example:**
  "Hypotensive post medications, possibly r/t sepsis."

- If within 24 hours after *Severe Sepsis Presentation Time* there is conflicting information within **two or more separate** pieces of physician/APN/PA documentation indicating hypotension is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, abstract based on the latest piece of documentation within the 24-hour period.
  **Example:**
  - Note 1200: “Antihypertensive discontinued due to hypotension.”
  - Note 1600: “Sepsis with hypotension and SIRS criteria.”
    - Hypotensive readings should be used.

- If within 24 hours after the *Severe Sepsis Presentation Time* there is physician/APN/PA or nursing documentation that a hypotensive reading is invalid, erroneous or questionable, disregard that reading when determining the presence of Septic Shock.
• If Septic Shock presentation is more than six hours after *Severe Sepsis Presentation Time*, choose Value “2.”

• Disregard documentation of Septic Shock in a discharge note, discharge summary, or documented after the time of discharge.

• The title or heading of an order set, protocol, checklist, alert, screening tool, etc. reflecting an infection, SIRS, Sepsis, Severe Sepsis, or Septic Shock should not be used to meet criteria.

• Documentation of a criterion or Septic Shock *within an* order set, protocol, checklist, alert, screening tool, etc., may be used if the following is true:
  - The documentation or value and recorded date and time is present and is the earliest date and time recorded for the criteria.

• Use of documentation in pre-hospital records (e.g., ambulance records, nursing home records) that is considered part of the medical record is acceptable for determining presence of Septic Shock.

• Choose Value “2” if within 6 hours after documentation meeting clinical criteria or physician/APN/PA documentation of Septic Shock there is additional physician/APN/PA documentation indicating:
  - Patient is not septic
  - Patient does not have Sepsis, Severe Sepsis, Septic Shock
  - Septic Shock is due to a viral, fungal or parasitic infection

• For documentation of Septic Shock accompanied by a qualifier, the table below should be used. Documentation containing a positive qualifier should be used to meet criteria, documentation containing a negative qualifier should not be used to meet criteria. Documentation containing both a positive and negative qualifier should not be used to meet criteria.

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<td>Questionable</td>
</tr>
<tr>
<td>Concern for</td>
<td></td>
</tr>
</tbody>
</table>

**Impacts:**
*Septic Shock Presentation Date*

**Rationale:** The data element is being updated to provide additional guidance to the abstractor.

**Description of Changes:**
*Notes for Abstraction*

**Change** fifth bullet point to:
- Use the earliest documented arrival date for patients who enter the Emergency Department with the following:
  - Septic shock clinical criteria met in pre-hospital records
  - Physician/APN/PA documentation of septic shock in pre-hospital records
Change sixth bullet point to:

• Use the earliest documented date patient arrives to floor or unit for admission for patients who are admitted with the following:
  o Septic shock clinical criteria met in pre-hospital records and patient is a direct admit
  o Physician/APN/PA documentation of septic shock in pre-hospital records and patient is a direct admit
  o Physician/APN/PA documentation that septic shock was present on arrival

Impacts:

Septic Shock Presentation Time

Rationale: The data element is being updated to provide additional guidance to the abstractor.

Description of Changes:

Notes for Abstraction

Change fifth bullet point to:

• Use the earliest documented arrival time for patients who enter the Emergency Department with the following:
  o Septic shock clinical criteria met in pre-hospital records
  o Physician/APN/PA documentation of septic shock in pre-hospital records
  o Physician/APN/PA documentation that septic shock was present on arrival

Change sixth bullet point to:

• Use the earliest documented time patient arrives to floor or unit for admission for patients who are admitted with the following:
  o Septic shock clinical criteria met in pre-hospital records and patient is a direct admit
  o Physician/APN/PA documentation of septic shock in pre-hospital records and patient is a direct admit
  o Physician/APN/PA documentation that septic shock was present on arrival

Impacts:

Severe Sepsis Present

Rationale: The data element is being updated to provide additional guidance to the abstractor.

Description of Changes:

Notes for Abstraction

Change to:

• Presence of Severe Sepsis may be identified based upon clinical criteria or physician/APN/PA documentation of Severe Sepsis.
  
  In order to establish the presence of Severe Sepsis by clinical criteria, all three clinical criteria (a, b, and c) must be met within 6 hours of each other. The three clinical criteria do not need to be documented in any particular order.

  a. Documentation of an infection.
     • Physician/APN/PA or nursing documentation referencing the presence of an infection is acceptable.
     • Physician/APN/PA, nursing, or pharmacist documentation indicating a patient is being treated with an antibiotic for an infection and that antibiotic
is documented as administered within 6 hours of criteria b or c is acceptable (e.g., Levaquin is documented in MAR for pneumonia and nursing documentation within 6 hours of criteria b and c that indicates a dose was given).

- If documentation of an infection is in a physician/APN/PA, nursing, or pharmacist note without a specific date and time or documented using the acronym POA, use the date and time the note was started or opened.
- If the note states an infection was present on arrival, use the earliest documented arrival date and time.
- If the note states an infection was present on admission, use the earliest documented date and time that the patient arrives to the floor or unit for admission.
- If an infection is documented and within 6 hours following the initial documentation of the infection, there is additional physician/APN/PA documentation indicating the infection is not present, disregard the initial documentation of the infection.

Examples:
- ED physician/APN/PA documents rule out UTI and pneumonia at 05:00. At 10:00 hospitalist documents no infection present. Disregard ED physician/APN/PA documentation of rule out UTI and pneumonia.
- ED physician/APN/PA documents suspected UTI and pneumonia at 09:00. At 12:30 infectious disease APN documents no UTI. Disregard the initial documentation of suspected UTI. Documentation of pneumonia is still valid to use for an infection.

- Documentation of an infection in an active problem list is acceptable if there is information in the medical record supporting the infection is current.
- If a condition documented in the medical record does not include the word “infection,” or is not in the Inclusion Guidelines for Abstraction infection list, consulting other medical resources (such as a medical dictionary) to identify whether or not the condition is an infection or is caused by an infection is acceptable.
  - If the other medical resource indicates the condition is an infection or is caused by an infection, it may be used to meet the suspected infection criteria.
  - If the other medical resource indicates the condition is NOT an infection and NOT caused by an infection, it may NOT be used to meet the suspected infection criteria.
  - If the other medical resource indicates the condition may or may not be an infection or may be caused by an infection or may be caused by something other than an infection, there must be additional documentation in the medical record supporting the condition is an infection (e.g., antibiotic ordered for the condition) to be used to meet the suspected infection criteria.
- If an antibiotic is ordered for a condition that may be inflammation or a sign or symptom of an infection this may be considered documentation of
an infection (e.g., ceftriaxone ordered for colitis, Zosyn 3.375 g IV q6hr for cough).

- Exclude documentation of viral, fungal, or parasitic infections.

b. **Two or more manifestations of systemic infection** according to the Systemic Inflammatory Response Syndrome (SIRS) criteria, which are:
   - Temperature $>$38.3 C or $<$36.0 C ($>$100.9 F or $<$96.8 F)
   - Heart rate (pulse) $>$90
   - Respiration $>$20 per minute
   - White blood cell count $>$12,000 or $<$4,000 or $>$10% bands

c. **Organ dysfunction**, evidenced by any one of the following:
   - Systolic blood pressure (SBP) $<$90 mmHg or mean arterial pressure $<$65 mmHg.
     - **Do not use** hypotensive BPs documented from an orthostatic BP evaluation.
   - Systolic blood pressure decrease of more than 40 mmHg.
     - Physician/APN/PA documentation must be present in the medical record indicating a $>$40 mmHg decrease in SBP has occurred and is related to infection, Severe Sepsis or Septic Shock and not other causes.
   - Acute respiratory failure as evidenced by a new need for invasive or non-invasive mechanical ventilation.
     - Documentation the patient is on mechanical ventilation.
     - Invasive mechanical ventilation requires an endotracheal or tracheostomy tube. Non-invasive mechanical ventilation may be referred to as BiPAP or CPAP.
     - New need for mechanical ventilation indicates the patient had a new need for mechanical ventilation that was not previously needed, or the patient had an increased need from intermittent to continuous mechanical ventilation.
     - Use the time mechanical ventilation was initiated or the time the mechanical ventilation changed from intermittent to continuous.
   - Creatinine $>$2.0
     - If there is physician/APN/PA documentation prior to or within 24 hours following presentation of severe sepsis that the patient has end stage renal disease (ESRD) and is on hemodialysis or peritoneal dialysis all reported creatinine levels should be disregarded as signs of organ dysfunction. ESRD (on hemodialysis or peritoneal dialysis) and creatinine levels or reference to elevated creatinine levels do not need to be included in the same physician/APN/PA documentation.
     - If there is physician/APN/PA documentation prior to or within 24 hours following presentation of severe sepsis of chronic renal disease (e.g., CKD I, II, or III, or “chronic renal insufficiency”) and the baseline creatinine is documented, creatinine values elevated $>$0.5 above baseline should be used as organ dysfunction (e.g., baseline 2.30, creatinine now 2.81).
   - Urine output $<$0.5 mL/kg/hour for 2 consecutive hours
Documentation must clearly indicate that urine output is being monitored hourly to be able to use this as organ dysfunction.

- Total Bilirubin >2 mg/dL (34.2 mmol/L)
- Platelet count <100,000
- INR >1.5 or aPTT >60 sec
  - If the suggested data source shows the patient was given an anticoagulant medication in Appendix C Table 5.3, an elevated INR or aPTT level should not be used as organ dysfunction. Physician/APN/PA documentation is not required.
- Lactate >2 mmol/L (18.0 mg/dL)

For the following, physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time is required.

- If the SIRS criteria or a sign of organ dysfunction is due to the following, it should not be used. Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation.
  - Normal for that patient
  - Is due to a chronic condition
  - Is due to a medication

**Examples:**
- Do not use value since the creatinine and the chronic condition are in the same documentation and section of the H&P.
  - H&P: Assessment Section
  - Renal Assessment
  - History of CKD
  - Creatinine 3.0
  - HD daily
  - Do not use the hypotensive readings since the medication is in the same sentence.
    - “Hypotensive after pain meds”

- If SIRS criteria or a sign of organ dysfunction is due to an acute condition that has a non-infectious source/process, it should not be used (Refer to Severe Sepsis Present criteria “a” to determine if the source of the acute condition is an infection).

**Examples:**
- “Lactate 4.3 r/t seizure” “Seizure post brain injury” (seizure is the acute condition and brain injury is the non-infectious source).
- “AKI, dehydrated due to nephrotoxic medication, creatinine 3.8.” (AKI and dehydration are the acute conditions and medication is the non-infectious source).
- APN Note: “Elevated Cr secondary to dehydration post DKA.”
  - Physician Note: “DKA likely due to patient non-compliance with meds.” (dehydration is the acute condition and DKA is the non-infectious source because it is due to medication non-compliance).

- If SIRS criteria or a sign of organ dysfunction should not be used based on the above guidance, all instances of less severe values should not be used.

**Examples:**
- “Platelet count 75 r/t chemo” (platelet counts ≥ 75 would not be used).
- “Cr 2.8, CKD” (creatinine values ≤ 2.8 would not be used).
  - If SIRS criteria or a sign of organ dysfunction is due to the following, the criteria value should be used.
    - Acute condition
      **Examples:**
      - Progress Note: “Lactate 4.3 r/t seizure.”
      - H&P: “AKI, dehydration, creatinine 3.8.”
    - Acute on chronic condition
      **Examples:**
      - H&P: “Acute on chronic renal failure, creatinine 2.8.”
      - Progress Note: “Hypotension due to acute exacerbation of chronic heart failure.”
    - Infection
      **Example:**
      Physician Note: “Cholecystitis with Hyperbilirubinemia.”
      Antibiotic Order Indication: “Cholecystitis” (The antibiotic indication confirms cholecystitis is an infection).
  - Documentation of a term that represents or is defined by a SIRS criteria or sign of organ dysfunction is acceptable in place of an abnormal value.
    **Examples** include but are not limited to:
    - Tachypnea (Respiration >20 per minutes)
    - A-fib with tachycardia, A-fib with RVR, or tachycardia (Heart rate >100)
    - Leukopenia (White blood cell count <4,000)
    - Leukocytosis (White blood cell count >12,000)
    - Thrombocytopenia (Platelet count <100,000)
    - Hypotension (Systolic blood pressure <90 mmHg)
  - If within the same physician/APN/PA documentation, there is conflicting documentation indicating SIRS criteria or sign of organ dysfunction is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, the criteria value should be used.
    **Examples:**
    - “Creatinine 4.3, CKD, potentially increasing due to worsening UTI,” creatinine value should be used.
    - “Thrombocytopenia possibly due to NSAID use, however complicated by sepsis,” platelet value should be used.
  - If within 24 hours after Severe Sepsis Presentation Time there is conflicting information within two or more separate pieces of physician/APN/PA documentation indicating SIRS criteria or sign of organ dysfunction is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, abstract based on the latest piece of documentation within the 24-hour period.
    **Examples:**
    - H&P 0900: “Tachypnea, on 2L NC, chronic emphysema.”
    - Consult 1500: “URI x 2 days with worsening tachypnea.”
      - Elevated respiratory rate should be used.
    - Note 1800: “Patient has been taking Lasix BID for 1 week, presenting with hypotension and dehydration.”
- Note 2230: “Dehydration and hypotension currently, Lasix discontinued, starting fluid resuscitation for possible sepsis.”
  - Hypotensive readings should be used.

- SIRS criteria or a sign of organ dysfunction obtained within the operating room (OR) should not be used.

- SIRS criteria or a sign of organ dysfunction due to artificial interventions should not be used.

  **Example:**
  Mechanical ventilator rate set at 24 and respiratory rate is 24, the respiratory rate would not be used for SIRS criteria.

- If an artificial intervention is unable to control a patient’s physiological function, the SIRS criteria or a sign of organ dysfunction should be used.

  **Example:**
  Mechanical ventilator rate set at 24 and respiratory rate at 28, the respiratory rate should be used for SIRS criteria.

- The title or heading of an order set, protocol, checklist, alert, screening tool, etc. reflecting an infection, SIRS, Organ Dysfunction, Sepsis, Severe Sepsis, or Septic Shock should not be used to meet criteria.

- Documentation of an infection, SIRS, Organ Dysfunction, Sepsis, Severe Sepsis, or Septic Shock within an order set, protocol, checklist, alert, screening tool, etc., may be used if the following is true:
  - The documentation or value and recorded date and time is present and is the earliest date and time recorded for the criteria.

- If within 24 hours after the *Severe Sepsis Presentation Time* there is physician/APN/PA or nursing documentation that SIRS criteria or sign of organ dysfunction is invalid, erroneous or questionable, disregard that value when determining the presence of Severe Sepsis.

- Use the time vital signs were taken or obtained. If time taken or obtained is not available, use recorded or documented time. Do not abstract vital signs from narrative charting unless there is no other documentation that reflects the time that the same vital sign was obtained.

- To determine the laboratory test value time for severe sepsis criteria, use the following sources in priority order.

  o **Primary source:**
    1. Laboratory test value result time from lab
  
  o **Supporting sources in priority order if primary source not available:**
    1. Time within a narrative note that is directly associated with the laboratory test value
    2. Time the laboratory test value is documented in a non-narrative location (e.g., sepsis flowsheet)
    3. Laboratory test sample draw or collected time
    4. Physician/APN/PA or nursing narrative note open time

- Use of documentation in pre-hospital records (e.g., ambulance records, nursing home records) that is considered part of the medical record is acceptable for determining presence of Severe Sepsis.

- If there is more than one presentation of Severe Sepsis in the record, abstract only the first presentation.
• If clinical criteria for Severe Sepsis are not met, but there is physician/APN/PA documentation of Severe Sepsis, choose Value “1.”
• If Severe Sepsis is met by physician/APN/PA documentation only, and is documented as due to a viral, fungal, or parasitic infection, the documentation of Severe Sepsis should not be used.
• If clinical criteria for Severe Sepsis are not documented and there is not physician/APN/PA documentation of Severe Sepsis, but there is physician/APN/PA documentation of Septic Shock, choose Value “1.”
• Disregard any documentation of SIRS criteria, organ dysfunction, an infection, Severe Sepsis, or Septic Shock in a discharge note, discharge summary, or documented after the time of discharge.
• Choose Value “2” if within 6 hours after documentation meeting clinical criteria or physician/APN/PA documentation of Severe Sepsis there is additional physician/APN/PA documentation indicating:
  o Patient is not septic
  o Patient does not have Sepsis, Severe Sepsis, or Septic Shock
  o Severe Sepsis or Septic Shock is due to a viral, fungal, or parasitic infection
• For documentation of an infection, Severe Sepsis, or Septic Shock accompanied by a qualifier, the table below should be used. Documentation containing a positive qualifier should be used to meet criteria, documentation containing a negative qualifier should not be used to meet criteria. Documentation containing both a positive and negative qualifier should not be used to meet criteria.

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</table>

Guidelines for Abstraction: Infections

Inclusions

Add new bullet points:
• C. difficile (C-diff)
• Septic

Impacts:

Severe Sepsis Presentation Date

Rationale: The data element is being updated to provide additional guidance to the abstractor.

Description of Changes:

Notes for Abstraction

Change fourth bullet point to:
• Use the earliest documented arrival date for patients who enter the Emergency Department with the following:
- Severe sepsis clinical criteria met in pre-hospital records
- Physician/APN/PA documentation of severe sepsis in pre-hospital records
- Physician/APN/PA documentation that severe sepsis was present on arrival

**Change** fifth bullet point to:
- Use the earliest documented date patient arrives to floor or unit for admission for patients who are admitted with the following:
  - Severe sepsis clinical criteria met in pre-hospital records and patient is a direct admit
  - Physician/APN/PA documentation of severe sepsis in pre-hospital records and patient is a direct admit
  - Physician/APN/PA documentation that severe sepsis was present on arrival

**Impacts:**

*Severe Sepsis Presentation Time*

**Rationale:** The data element is being updated to provide additional guidance to the abstractor.

**Description of Changes:**

**Notes for Abstraction**

**Change** fourth bullet point to:
- Use the earliest documented arrival time for patients who enter the Emergency Department with the following:
  - Severe sepsis clinical criteria met in pre-hospital records
  - Physician/APN/PA documentation of severe sepsis in pre-hospital records
  - Physician/APN/PA documentation that severe sepsis was present on arrival

**Change** fifth bullet point to:
- Use the earliest documented time patient arrives to floor or unit for admission for patients who are admitted with the following:
  - Severe sepsis clinical criteria met in pre-hospital records and patient is a direct admit
  - Physician/APN/PA documentation of severe sepsis in pre-hospital records and patient is a direct admit
  - Physician/APN/PA documentation that severe sepsis was present on admission

**Impacts:**

*Tobacco Use Status*

**Rationale:** The data element is being updated to provide clarification for abstraction of cognitive impairment.

**Description of Changes:**

**Notes for Abstraction**

**Remove** fifteenth bullet point:
- If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication) Value “6” cannot be selected.

**Remove** sixteenth bullet point:
- If there is documentation that the patient was intubated on the day of admission (Day 0) and remains intubated the entire first day of admission (Day 1), select Value “6” as the patient is unable to answer.
Change sub-bullets under eighteenth bullet point to:

Examples of cognitive impairment include:
- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive impairment
- Cognitively impaired
- Cognitive impairment due to acute substance use; overdose, acute intoxication
- Confused
- Dementia
- Intubation
- Memory loss
- Mentally handicapped
- Obtunded
- Psychotic/psychosis with documented symptoms
- Sedation

SECTION 2 – Measurement Information

Subsection 2.1 – Severe Sepsis and Septic Shock (SEP)

Impacts:
SEP Data Elements Table

Rationale: The SEP Data Elements Table is being updated to reflect removal of the Documentation of Septic Shock data element in the SEP-1 measure.

Description of Changes:
Remove row in its entirety:
Documentation of Septic Shock

Impacts:
Data Element List

Rationale: The Documentation of Septic Shock data element is being removed because it is no longer needed as a trigger for crystalloid fluid administration after further algorithm revision.

Description of Changes:
Remove:
- Documentation of Septic Shock

Impacts:
Numerator Statement

Rationale: The numerator statement is being revised for clarification.

Description of Changes:
Change to:
Numerator Statement: Patients who received ALL of the following:
Within three hours of presentation of severe sepsis:
  - Initial lactate level measurement
  - Broad spectrum or other antibiotics administered
  - Blood cultures drawn prior to antibiotics
AND received within six hours of presentation of severe sepsis, ONLY if the initial lactate is elevated:
• Repeat lactate level measurement AND within three hours of initial hypotension:
  • Resuscitation with 30 mL/kg crystalloid fluids
OR within three hours of septic shock:
  • Resuscitation with 30 mL/kg crystalloid fluids
AND within six hours of septic shock presentation, ONLY if hypotension persists after fluid administration:
  • Vasopressors are administered
AND within six hours of septic shock presentation, if hypotension persists after fluid administration or initial lactate >= 4 mmol/L:
  • Repeat volume status and tissue perfusion assessment is performed

Impacts:
Algorithm

Rationale: The SEP-1 algorithm is being updated due to the removal of the Documentation of Septic Shock data element and updates for clearer algorithm flow.

Description of Changes:
Change to:
Numerator Statement: Patients who received ALL of the following:
Within three hours of presentation of severe sepsis:
  • Initial lactate level measurement
  • Broad spectrum or other antibiotics administered
  • Blood cultures drawn prior to antibiotics
AND received within six hours of presentation of severe sepsis, ONLY if the initial lactate is elevated:
  • Repeat lactate level measurement
AND within three hours of initial hypotension:
  • Resuscitation with 30 mL/kg crystalloid fluids
OR within three hours of septic shock:
  • Resuscitation with 30 mL/kg crystalloid fluids
AND within six hours of septic shock presentation, ONLY if hypotension persists after fluid administration:
  • Vasopressors are administered
AND within six hours of septic shock presentation, if hypotension persists after fluid administration or initial lactate >= 4 mmol/L:
  • Repeat volume status and tissue perfusion assessment is performed

Remove from algorithm flow:
Documentation of Septic Shock
Initial Hypotension second check

Add to algorithm flow, second check of:
Crystalloid Fluid Administration
Crystalloid Fluid Administration Date
Crystalloid Fluid Administration Time
Persistent Hypotension
Subsection 2.2 – Venous Thromboembolism (VTE) *(no updates)*

Subsection 2.4 – Global Initial Patient Population (ED, IMM, TOB, SUB) *(no updates)*

Subsection 2.5 – Emergency Department (ED) *(no updates)*

Subsection 2.6 - Prevention

2.6.1 - Immunization (IMM)

**Impacts:**
IMM-2

**Rationale:** The IMM-2 MIF is being updated with a new reference.

**Description of Changes:**

**Selected References**

**Add** new reference:

2.6.2 - Substance Use (SUB) *(no updates)*

2.6.3 - Tobacco Treatment (TOB)

**Impacts:**
Algorithm

**Rationale:** The algorithm is being revised to correct an error in the name of a data element.

**Description of Changes:**

**Change** diamond labeled Reason for No Tobacco Cessation Medication During Hospital Stay

**To:**
Reason for No Tobacco Cessation Medication During the Hospital Stay

SECTION 3 – Missing and Invalid Data

**Impacts:**
Data Collection and the Unable to be Determined (UTD) Allowable Value

**Rationale:** An update is being made to reflect current manual specifications.

**Description of Changes:**

**Change** in fourth bullet, first sentence:

**ICU Admission or Transfer**

**To:**

**Blood Culture Collection Date**

SECTION 4 – Population and Sampling Specifications *(no updates)*
SECTION 9 – Data Transmission

Transmission Overview (no updates)

Transmission Alphabetical Data Dictionary (no updates)

Hospital Clinical Data XML File Layout

Impacts: 
Crystalloid Fluid Administration

Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Data Elements Info
Change Suggested Data Collection Question from:
Were crystalloid fluids initiated prior to, at the time of, or after the presentation of Initial Hypotension, Initial Lactate Level Result >=4 mmol/L, or physician/APN/PA Documentation of Septic Shock? 
To:
Were crystalloid fluids initiated within the specified time frame AND completely infused based on the target ordered volume?

Impacts: 
Documentation of Septic Shock

Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Data Elements Info
Remove the following element
Documentation of Septic Shock
Add the following data element under Retired or Deleted Data Elements Effective 01/01/2019 Discharges:
Documentation of Septic Shock

Impacts: 
Initial Hypotension

Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Data Elements Info
Change Suggested Data Collection Question from:
Was initial hypotension present 6 hours prior to or within 6 hours following Severe Sepsis Presentation Data and Time? 
To:
Was initial hypotension present within the specified time frame?
Impacts:
*Initial Lactate Level Collection*

Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Data Elements Info

**Change** Suggested Data Collection Question from:
Was an initial lactate level drawn between 6 hours prior to and 3 hours following the presentation of severe sepsis?

**To:**
Was an initial lactate level drawn within the specified time frame?

Impacts:
*Prescription for Alcohol or Drug Disorder Medication*
*Prescription for Tobacco Cessation Medication*

Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Data Elements Info

**Change** Allowable Value 3 from:
The patient’s residence is not in the USA.

**To:**
The patient is being discharged to a residence outside the USA; is released to a court hearing and does not return; is being discharged to jail/law enforcement.

Impacts:
*Referral for Addictions Treatment*
*Referral for Outpatient Tobacco Cessation Counseling*

Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Data Elements Info

**Change** Allowable Value 4 from:
The patient’s residence is not in the USA.

**To:**
The patient is being discharged to a residence outside the USA; is released to a court hearing and does not return; is being discharged to jail/law enforcement.

**Hospital Initial Patient Population Data XML File Layout (no updates)**

**SECTION 10 – CMS Outcome/Structural Measures**

Subsection 10.1 – CMS Outcome Measures (no updates)

Subsection 10.2 – Structural Measures (no updates)
APPENDICES

Appendix A – ICD-10 Code Tables (Word and Excel) (no updates)

Appendix C – Medication Tables (Word and Excel)

Impacts:
Table 5.0: Antibiotic Monotherapy, Sepsis

Rationale: The table is being updated to remove discontinued antibiotics, decrease redundancy, and arrange medications under each column appropriately.

Description of Changes:
Change first column header to:
Antibiotic Selection Options
(includes trade name or generic name)

Remove trade name with respective generic name crosswalk rows in their entirety:
Left column: Ampicillin/sulbactam
Right column: Ampicillin/sulbactam
Left column: Cefepime
Right column: Cefepime
Left column: Ceftotaxime
Right column: Ceftotaxime
Left column: Ceftarolone fosamil
Right column: Ceftarolone fosamil
Left column: Ceftazidime/avibactam
Right column: Ceftazidime/avibactam
Left column: Ceftazidime
Right Column: Ceftazidime
Left column: Ceftolozane/tazobactam
Right column: Ceftolozane/tazobactam
Left column: Doriopenem
Right column: Doriopenem
Left column: Ertapenem
Right column: Ertapenem
Left column: Imipenem/Cilastatin
Right column: Imipenem/Cilastatin
Left column: Levofloxacain
Right column: Levofloxacain
Left column: Meropenem
Right column: Meropenem
Left column: Moxifloxacain
Right column: Moxifloxacain
Left column: Piperacillin/tazobactam
Right column: Piperacillin/tazobactam
Impacts:
Table 5.1: Antibiotic Generic/Trade Name Crosswalk, Sepsis

Rationale: The table is being updated to remove discontinued antibiotics, decrease redundancy, and arrange medications under each column appropriately.

Description of Changes:
Change first column header to:
Antibiotic Selection Options
(includes trade name or generic name)

Remove the following trade name with respective generic name crosswalk rows in their entirety, under Aminoglycosides section:
Left column: Garamycin
Right column: Gentamicin

Left column: Kantrex
Right column: Kanamycin

Left column: Nebcin
Right column: Tobramycin

Remove the following trade name with respective generic name crosswalk row in its entirety, under Aztreonam section:
Left column: Aztreonam
Right column: Aztreonam

Remove the following trade name with respective generic name crosswalk rows in their entirety, under Cephalosporins (1st and 2nd Generation) section:
Left column: Cefazolin
Right column: Cefazolin

Left column: Cefotetan
Right column: Cefotetan

Left column: Cefoxitin
Right column: Cefoxitin

Left column: Ceftin
Right column: Cefuroxime

Remove the following trade name with respective generic name crosswalk rows in their entirety, under Ciprofloxacin section:
Left column: Cipro
Right column: Ciprofloxacin
Remove the following trade name with respective generic name crosswalk row in its entirety, under Clindamycin IV section:
Left column: Clindamycin
Right column: Clindamycin

Remove the following trade name with respective generic name crosswalk row in its entirety, under Daptomycin section:
Left column: Daptomycin
Right column: Daptomycin

Remove the following trade name with respective generic name crosswalk rows in their entirety, under Glycopeptides section:
Left column: Teicoplanin
Right column: Teicoplanin
Left column: Telavancin
Right column: Telavancin
Left column: Vancomycin
Right column: Vancomycin

Remove the following trade name with respective generic name crosswalk row in its entirety, under Linezolid section:
Left column: Linezolid
Right column: Linezolid

Remove the following trade name with respective generic name crosswalk rows in their entirety, under Macrolides section:
Left column: Azithromycin
Right column: Azithromycin
Left column: Erythromycin
Right column: Erythromycin
Left column: Erythromycin
Right column: Erythromycin
Left column: Ketek
Right column: Telithromycin
Left column: Telithromycin
Right column: Telithromycin
Impacts:
Table 5.2: Vasopressors for Septic Shock

Rationale: The table is being updated to remove discontinued vasopressor medications.

Description of Changes:
**Change** under Brand Name column:
Inotropine
**To:**
Dopamine

Pitressin
**To:**
Vasopressin

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Appendix D – Glossary of Terms *(no updates)*

Appendix E – Overview of Measure Information Form and Flowchart Formats *(no updates)*

Appendix F – Measure Name Crosswalk *(no updates)*

Appendix G – Resources *(no updates)*

Appendix H – Miscellaneous Tables *(no updates)*

Appendix P – Preview Section *(no updates)*