Guidelines for Using Release Notes
The Release Notes provides modifications to the Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.3. 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 01/01/2018, 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**.
# Table of Contents

Note: click on any section title in the Release Notes to return to Table of Contents page.

Table of Contents ..................................................................................................................... 2  
Acknowledgement (no updates) ............................................................................................. 2  
Introduction (no updates) ........................................................................................................ 2  
Using the Specifications Manual for National Hospital Inpatient Quality Measures (no updates)..................................................................................................................................... 2  
SECTION 1 – Data Dictionary .................................................................................................. 2  
  Introduction to Data Dictionary ..................................................................................................... 2  
  Alphabetical Data Dictionary ........................................................................................................ 3  
SECTION 2 – Measurement Information ............................................................................... 65  
  Subsection 2.1 – Severe Sepsis and Septic Shock (SEP).......................................................... 65  
  Subsection 2.2 – Venous Thromboembolism (VTE)............................................................... 67  
  Subsection 2.4 – Global Initial Patient Population (ED, IMM, TOB, SUB) (no updates) ........67  
  Subsection 2.5 – Emergency Department (ED) .......................................................................... 68  
  Subsection 2.6 - Prevention ....................................................................................................... 68  
    2.6.1 - Immunization (IMM) .................................................................................................... 68  
    2.6.2 - Substance Use (SUB) ................................................................................................. 68  
    2.6.3 - Tobacco Treatment (TOB) .......................................................................................... 69  
SECTION 3 – Missing and Invalid Data (no updates)................................................................. 75  
SECTION 4 – Population and Sampling Specifications (no updates) ........................................ 75  
SECTION 9 – Data Transmission ............................................................................................. 75  
  Transmission Overview .............................................................................................................. 75  
  Transmission Alphabetical Data Dictionary (no updates) ........................................................ 76  
  Hospital Clinical Data XML File Layout ....................................................................................... 76  
  Hospital Initial Patient Population Data XML File Layout (no updates) ................................. 85  
SECTION 10 – CMS Outcome/Structural Measures ............................................................... 85  
  Subsection 10.1 – CMS Outcome Measures (no updates) ....................................................... 85  
  Subsection 10.2 – Structural Measures (no updates) ................................................................. 85  
APPENDICES .......................................................................................................................... 86  
  Appendix A – ICD-10 Code Tables (Word and Excel – no updates) ........................................ 86  
  Appendix C – Medication Tables (Word and Excel) ................................................................. 86  
  Appendix D – Glossary of Terms (no updates) ......................................................................... 86  
  Appendix E – Overview of Measure Information Form and Flowchart Formats (no updates) .... 86  
  Appendix F – Measure Name Crosswalk (no updates) ............................................................. 86  
  Appendix G – Resources (no updates) ..................................................................................... 86  
  Appendix H – Miscellaneous Tables (no updates) .................................................................... 86  
  Appendix P – Preview Section (no updates) ............................................................................. 86
The content below is organized to follow the Table of Contents in the specifications manual.

**Table of Contents**

**Impacts:**
Section 2.6.2 - Substance Use (SUB)

**Rationale:** Effective January 1, 2018, the SUB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

**Description of Changes:**
Remove under Measure Information Form (MIF) and Flowchart (Algorithm):
SUB-4

**Impacts:**
Section 2.6.3 – Tobacco Treatment (TOB)

**Rationale:** Effective January 1, 2018, the TOB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

**Description of Changes:**
Remove under Measure Information Form (MIF) and Flowchart (Algorithm):
TOB-4

**Acknowledgement (no updates)**

**Introduction (no updates)**

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

**SECTION 1 – Data Dictionary**

**Introduction to Data Dictionary**

**Impacts:**
Introduction

**Rationale:** The data element *Patient HIC#* is being deleted as it is not used by CMS in the abstraction process and may contain the patient's Social Security Number.

**Description of Changes:**
Remove from data element list:

- *Patient HIC#*
**Alphabetical Data Dictionary**

**Impacts:**
Index and Data Elements

**Rationale:** Effective January 1, 2018, the SUB-4 and TOB-4 measures are being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

**Description of Changes:**
*Remove* rows in index and data elements in their entirety:
- *Alcohol or Drug Use Status Post Discharge – Counseling*
- *Alcohol or Drug Use Status Post Discharge - Medication*
- *Alcohol Use Status Post Discharge – Quit Status*
- *Drug Use Status Post Discharge – Quit Status*
- *Follow-up Contact*
- *Follow-up Contact Date*
- *Tobacco Use Status Post Discharge - Counseling*
- *Tobacco Use Status Post Discharge - Medication*
- *Tobacco Use Status Post Discharge – Quit Status*

**Impacts:**
*Administrative Contraindication to Care, Septic Shock*

**Rationale:** The Notes for Abstraction and Inclusion Guidelines for Abstraction are being updated to provide additional guidance to the abstractor.

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

**Change to:**
- Only acceptable sources are physician/APN/PA or nursing documentation.
- Documentation indicating patient or authorized patient advocate has refused blood draws, IV or IO fluid administration, or vasopressor administration prior to or within 6 hours following presentation of septic shock can be used to select Value “1.”
- Documentation of refusal of care that would result in blood draws, IV or IO fluids or vasopressors not being administered is acceptable.
- If intraosseous access or placement of a central line is refused, consider this refusal of vasopressors.
- For refusal of blood draws:
  - Documented refusal of blood draws is acceptable.
  - Refusal of specific blood draws or blood tests that do not impact the ability to meet the requirements of the SEP-1 measure data elements should not be used.
    *Examples:*
    - Patient refused HIV blood test.
    - Patient refused arterial blood gas (ABG).
- For refusal of IV or IO fluids:
  - Documented refusal of fluids or IV or IO fluids is acceptable.
- For refusal of vasopressor:
  - Documented refusal of medications or vasopressors is acceptable.
Inclusion Guidelines for Abstraction:

Change to:
- Declined
- Refused
- Requests not to be given

Impacts:

Administrative Contraindication to Care, Severe Sepsis

Rationale: The Notes for Abstraction and Inclusion Guidelines for Abstraction are being updated to provide additional guidance to the abstractor.

Description of Changes:

Notes for Abstraction

Change to:
- Only acceptable sources are physician/APN/PA or nursing documentation.
- Documentation indicating patient or authorized patient advocate has refused blood draw, IV or IO fluid administration, or IV or IO antibiotic administration prior to or within 6 hours following presentation of severe sepsis can be used to select Value “1.”
- Documentation of refusal of care that would result in blood draws, IV or IO fluids or IV or IO antibiotics not being administered is acceptable.
- For refusal of blood draws:
  - Documented refusal of blood draws is acceptable.
  - Refusal of specific blood draws or blood tests that do not impact the ability to meet the requirements of the SEP-1 measure data elements should not be used.
    
    **Examples:**
    - Patient refused HIV blood test.
    - Patient refused arterial blood gas (ABG).

- For refusal of IV or IO fluids:
  - Documented refusal of fluids or IV or IO fluids is acceptable.
- For refusal of IV or IO antibiotic administration:
  - Documented refusal of medications is acceptable.
  - Documented refusal of antibiotics or IV or IO antibiotics is acceptable.

Inclusion Guidelines for Abstraction

Change to:
- Declined
- Refused
- Requests not to be given

Impacts:

Alcohol Use Status

Rationale: The data element is being updated to provide clarification of the screening time frame, conversion information on the blood alcohol level, and guidance on screening of the intubated patient.

Description of Changes:

Definition

Change first sentence to:
Documentation of the adult patient’s alcohol use status using a validated screening questionnaire for **unhealthy** alcohol use within the first day of admission (by end of Day 1).

**Allowable Values**

**Change from:**

1. The patient is screened with a validated tool within the first day of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.
2. The patient was screened with a validated tool within the first day of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.
3. The patient was screened with a non-validated tool within the first day of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.
4. The patient was screened with a non-validated tool within the first day of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.
5. The patient refused the screen for alcohol use within the first day of admission.
6. The patient was not screened for alcohol use during the first day of admission or unable to determine from medical record documentation.
7. The patient was not screened for alcohol use during the first day of admission because of cognitive impairment.

**To:**

1. The patient is screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.
2. The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.
3. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.
4. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.
5. The patient refused the screen for alcohol use within the first day of admission (by end of Day 1).
6. The patient was not screened for alcohol use during the first day of admission (by end of Day 1) or unable to determine from medical record documentation.
7. The patient was not screened for alcohol use during the first day of admission (by end of Day 1) because of cognitive impairment.

**Notes for Abstraction**

**Change to:**

- The alcohol use status screening must have occurred within the first day of admission (by end of Day 1). This includes the day of admission which is defined as Day 0 and the day after admission which is defined as Day 1.

**EXCEPTION:**

If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or
observation unit, the screening documentation must be present in the current medical record.

- If patient has a blood alcohol test with a result of .08 g/dL or greater or the clinician documents the patient was acutely intoxicated per blood alcohol test results select Value “2.”
  - The 0.08 limit is a blood alcohol concentration (BAC) reported in g/dL. If results are given in mg/dL, convert to g/dL by moving the decimal point 3 places to the left.
    - Examples:
      - A 100 mg/dL serum ethanol level is equivalent to a 0.10 (g/dL) BAC.
      - An 80 mg/dL serum ethanol level is equivalent to a 0.08 g/dL BAC.

- Screening may be done with a “validated” Single Alcohol Screening Question (SASQ) in order to identify those patients with no risk or low risk or who do not drink. Further screening should be done with a validated tool for those patients with a positive result to determine if there is need for a brief intervention.
  - Examples of SASQs include:
    - “On any single occasion during the past 3 months, have you had more than 5 drinks containing alcohol?” (Yes response is considered positive.)
    - ”When was the last time you had more than X drinks in 1 day?” (X = 4 for women and 5 for men) (Within the last 3 months is considered positive.)
    - “How many times in the past year have you had X or more drinks in a day?” (X = 5 men and 4 women) (Response of >1 is considered positive.)
    - How often have you had 6 or more drinks on one occasion in the past year? (Ever in the past year considered positive.)
    - How often do you have X or more drinks on one occasion? (X = 4 for women and 5 for men) (Ever in the past year considered positive.)

- Refer to the Inclusion Guidelines for examples of commonly used validated screening tools; note that the CAGE, although a validated tool, is not recommended for this measure set.

- Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first day of admission (by end of Day 1).
- 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.
- If there is documentation within the first day of admission (by end of Day 1) that the patient was psychotic with documented symptoms, e.g., hallucinating, non-communicative, catatonic, etc., which prevented them from answering questions reliably, they would be considered cognitively impaired.
- 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.
- If there is documentation in the medical record indicating the patient drinks alcohol and conflicting documentation indicating the patient does not drink alcohol, select Value “6” since alcohol use status is unable to be determined.
• When there is conflicting information in the record with regard to risk, for instance, the results from a validated screening tool are documented as both low AND moderate/high risk, select Value “2” indicating the highest risk.

• Documentation of cognitive impairment overrides documentation of an alcohol use screen and therefore would not be considered "conflicting documentation." Even if the family or others tell staff the patient uses alcohol, the patient could not be counseled due to cognitive impairment. Select Value “7.”

• If there is documentation within the first day of admission (by end of Day 1) of any of the examples below, select Value “7” regardless of conflicting documentation.

  Examples of cognitive impairment include:
  o Altered Level of Consciousness (LOC)
  o Altered Mental Status
  o Cognitive impairment
  o Cognitively impaired
  o Dementia
  o Confused
  o Memory loss
  o Mentally retarded

• Obtunded
• Psychotic/psychosis

Impacts:
Bedside Cardiovascular Ultrasound Date

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
On what date was a bedside cardiovascular ultrasound performed?

Impacts:
Bedside Cardiovascular Ultrasound Date

Rationale: The Notes for Abstraction are being updated to include additional guidance to the abstractor.

Description of Changes:
Notes for Abstraction
Change first bullet point to:
• Documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.

Add new second bullet point:
• If there are multiple bedside cardiovascular ultrasounds performed, abstract the date and time of the latest measurement documented within the allowable time window.
Remove last bullet point:

- If multiple bedside cardiovascular ultrasounds were done in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date of the procedure that was done latest within the time window.

**Impacts:**

*Bedside Cardiovascular Ultrasound Performed*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**

*Suggested Data Collection Question*

**Change to:**

Was a bedside cardiovascular ultrasound performed?

**Impacts:**

*Bedside Cardiovascular Ultrasound Performed*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are no assessments performed.

**Description of Changes:**

*Notes for Abstraction*

**Change first bullet point to:**

- Documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date, Septic Shock Presentation Time*.

Remove fifth bullet point:

- If multiple bedside cardiovascular ultrasounds were done in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date of the procedure that was done latest within the time window.

**Change last bullet point to:**

- If no bedside cardiovascular ultrasounds were documented or documentation reflects the assessment was not performed in the allowable time window, choose Value “2.”

**Impacts:**

*Bedside Cardiovascular Ultrasound Time*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**

*Suggested Data Collection Question*

**Change to:**

At what time was a bedside cardiovascular ultrasound performed?
Impacts:
*Bedside Cardiovascular Ultrasound Time*

**Rationale:** The Notes for Abstraction are being updated to include additional guidance to the abstractor.

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

**Change** first bullet point to:
- Documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date*, *Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.

**Add** new second bullet point:
- If there are multiple bedside cardiovascular ultrasounds performed, abstract the time of the latest measurement documented within the allowable time window.

**Remove** last bullet point:
- If multiple bedside cardiovascular ultrasounds were done in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the time of the procedure that was done latest within the time window.

**Impacts:**
*Blood Culture Collection Acceptable Delay*

**Rationale:** The Notes for Abstraction are being updated to provide additional guidance to the abstractor.

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

**Change** first bullet point to:
- Only the following situations demonstrate an acceptable delay, resulting in the blood culture being drawn after the *Broad Spectrum or Other Antibiotic Administration Date* and *Time*. If there is an acceptable delay, choose Value “1.”

**Change** first sub-bullet point, under first bullet point to:
- Surgical patients who receive a pre-op or post-op prophylactic antibiotic and within 24 hours of that antibiotic dose develop severe sepsis and then have a blood culture drawn.

**Remove** from the second and third sub-bullet points:
*IV*

**Change** fourth sub-bullet point to:
- A physician/APN/PA documented reason for the delay, such as waiting to start the antibiotic or to draw the blood culture could cause a delay which would be detrimental to the patient.

**Add** new fifth sub-bullet point, under first bullet point:
- Obstetric patients given prophylactic antibiotics for ruptured membranes, group B strep, or prior to a caesarean section.
Remove the second bullet point:

- If there is documentation supporting an acceptable delay in the collection of a blood culture, choose Value “1.”

Impacts:

Brief Intervention

Rationale: An update is being made to the Suggested Data Sources to provide clarification for abstraction.

Description of Changes:

Suggested Data Sources

Remove first bullet point:

- Coding documents

Impacts:

Broad Spectrum or Other Antibiotic Administration

Rationale: The Definition, Suggested Data Collection Question, and Allowable Values were updated to remove intravenous route.

Description of Changes:

Definition, Suggested Data Collection Question, Allowable Values

Remove:

Intravenously

Allowable Values

Change from:

1 (Yes) A broad spectrum or other antibiotic was administered intravenously in the time window 24 hours prior to or 3 hours following the presentation of severe sepsis.

2 (No) No antibiotic was administered intravenously in the time window 24 hours prior to or 3 hours following the presentation of severe sepsis, or unable to determine.

To:

1 (Yes) A broad spectrum or other antibiotic was administered in the time window 24 hours prior to or 3 hours following the presentation of severe sepsis.

2 (No) No antibiotic was administered in the time window 24 hours prior to or 3 hours following the presentation of severe sepsis, or unable to determine.

Impacts:

Broad Spectrum or Other Antibiotic Administration

Rationale: The Notes for Abstraction are being updated to provide additional guidance to the abstractor.

Description of Changes:

Notes for Abstraction

Change first bullet point to:

- Only IV antibiotic administered in the 24 hours prior to or 3 hours after severe sepsis presentation is acceptable.

EXCEPTION:

If there is documentation indicating IV access could not be established, antibiotics administered via intramuscular (IM) or intraosseous (IO) started in the
24 hours prior to or 3 hours after the severe sepsis presentation is acceptable to select Value “1.”

**Change** second, third, fourth, and fifth bullet points to:
- If the patient started on an antibiotic within the 24 hours preceding or 3 hours following the *Severe Sepsis Presentation Date and Time*, choose Value “1.”
- If no antibiotic was started within the 24 hours preceding or 3 hours following the *Severe Sepsis Presentation Date and Time*, choose Value “2.”
- Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of the antibiotic (i.e., antibiotic name, route, date and time).
- A physician/APN/PA order for antibiotics is not sufficient unless the antibiotic ordered was marked as “started” with date/time noted.

**Change** seventh and eighth bullet points to:
- Do not cross reference between different sources to infer that an antibiotic was started if it was documented only with name/date/time given but no route indicated. The route on the MAR for an antibiotic cannot be used as the route for a dose of that same antibiotic on another form.
- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as started. The methods may vary. Whatever method is used, it must be clear that the dose was administered.

**Add** new twelfth bullet point:
- If the antibiotic name, route, date or time is missing, disregard that dose.

**Change** last bullet point to:
- Pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record should be used for abstracting antibiotics.

**Impacts:**
- Broad Spectrum or Other Antibiotic Administration
- Broad Spectrum or Other Antibiotic Administration Date
- Broad Spectrum or Other Antibiotic Administration Selection
- Broad Spectrum or Other Antibiotic Administration Time

**Rationale:** The Inclusion Guidelines for Abstraction are being updated to include additional routes that are acceptable.

**Description of Changes:**
- Inclusion Guidelines for Abstraction

**Add** new bullet points:
- Intramuscular or IM
- Intraosseous or IO
Impacts:
*Broad Spectrum or Other Antibiotic Administration Date*

*Rationale:* The Notes for Abstraction are being updated to include additional guidance to the abstractor.

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

**Change to:**
- Only IV antibiotic administered in the 24 hours prior to or 3 hours after severe sepsis presentation is acceptable.

  **EXCEPTION:**
  If there is documentation indicating IV access could not be established, antibiotics administered via intramuscular (IM) or intraosseous (IO) started in the 24 hours prior to or 3 hours after the severe sepsis presentation is acceptable.
- If one or more antibiotic was started within the 24 hours prior to presentation of severe sepsis, and none of those same antibiotics were started more than 24 hours prior to presentation, abstract the earliest dose started in the 24 hours prior to presentation of severe sepsis.
- If one or more antibiotics were administered within 24 hours prior to severe sepsis presentation, abstract the earliest date and time that antibiotic was started. This may be the same date as the date of presentation or may be a date any time before presentation. Do not review for antibiotic doses started more than 72 hours prior to severe sepsis presentation.

**Examples:**

<table>
<thead>
<tr>
<th>More than 24 hours Before Presentation (Max. lookback 72 hrs.)</th>
<th>24 hours Before Presentation</th>
<th>Severe Sepsis</th>
<th>3 Hours After Presentation</th>
<th>Antibiotic Dose to Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
<td>First dose of A</td>
</tr>
<tr>
<td>B</td>
<td>C</td>
<td>C</td>
<td></td>
<td>Antibiotic B</td>
</tr>
<tr>
<td>G</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>First dose of A</td>
</tr>
<tr>
<td>B</td>
<td>B</td>
<td>B</td>
<td></td>
<td>First dose of B</td>
</tr>
<tr>
<td>C</td>
<td>D</td>
<td>C</td>
<td>C</td>
<td>First dose of C</td>
</tr>
</tbody>
</table>

- If one or more antibiotic was started within the 3 hours after presentation of severe sepsis, and the patient did not receive an antibiotic in the 24 hours before severe sepsis presentation, abstract the dose started closest to severe sepsis presentation.

**Examples:**

<table>
<thead>
<tr>
<th>More than 24 hours Before Presentation (Max. lookback 72 hrs. from presentation)</th>
<th>24 hours Before Presentation</th>
<th>Severe Sepsis</th>
<th>3 Hours After Presentation</th>
<th>Antibiotic Dose to Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td></td>
<td>L</td>
<td></td>
<td>Antibiotic L</td>
</tr>
<tr>
<td>K</td>
<td></td>
<td>K</td>
<td>A</td>
<td>Dose of K in 3 hr. period</td>
</tr>
</tbody>
</table>

- If antibiotics were administered both 24 hours prior to and within 3 hours after the time of presentation of severe sepsis, abstract the earliest date and time that an antibiotic in the 24 hours prior was started. This may be the same date as the date of presentation.
or may be a date any time before presentation. Do not review for antibiotic doses started more than 72 hours prior to severe sepsis presentation.

**Examples:**

<table>
<thead>
<tr>
<th>More than 24 hours Before Presentation (Max. lookback 72 hrs. from presentation)</th>
<th>24 hours Before Presentation</th>
<th>Severe Sepsis</th>
<th>3 Hours After Presentation</th>
<th>Antibiotic Dose to Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>D</td>
<td>D</td>
<td>First dose of D</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>F</td>
<td></td>
<td>Antibiotic E</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>E</td>
<td>E</td>
<td>L</td>
<td>First dose of E</td>
</tr>
<tr>
<td>M</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>M</td>
</tr>
<tr>
<td>M</td>
<td>A</td>
<td>B</td>
<td>M</td>
<td>A</td>
</tr>
</tbody>
</table>

- Stop abstracting 3 hours after the presentation of severe sepsis.
- If no antibiotic was started in the 24 hours before or 3 hours after severe sepsis presentation, enter "UTD."
- Do not cross reference between different sources to infer that an antibiotic was started if it was documented only with name/date/time given but no route indicated. The route on the MAR for an antibiotic cannot be used as the route for a dose of the same antibiotic on another form.
- If the antibiotic name, route, date or time is missing, disregard that dose.
- Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of the specific antibiotic within the time window of 24 hours prior to or 3 hours following the presentation of severe sepsis.

**Examples:**

- A physician order for IV antibiotics is not sufficient unless the antibiotic ordered was marked as “started” with date/time noted.
- Do not collect antibiotics documented on an operative report unless the surgeon states that the surgeon actually administered the dose.

- Specific documentation by one person that another person administered the antibiotic is acceptable for determining the date and time of administration.

**Example:**

OR nurse, S. Smith RN, documents, “Cefazolin 1 gm IV given on 1/7/20xx at 0500 per J Doe RN.” This dose can be abstracted as given if not documented by the person that gave the dose.

- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as started. The methods may vary. Whatever method is used, it must be clear that the dose was administered.
- Do not abstract test doses of antibiotics.
- Do not abstract antibiotics from sources that do not represent actual administration.
Examples that do not represent actual administration:
Pre-Op Checklist states:
X IV Started at 1730
X Preop Antibiotic Given at 1800
X Lab on Chart
Operative report states: IV antibiotics were given prior to procedure

- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was started during the specified timeframe.

  Example:
  Narrative states: “Ancef 1 gram given IV prior to incision.” No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data (no date and time).

- Pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record should be used for abstracting antibiotics.

Impacts:
Broad Spectrum or Other Antibiotic Administration Date
Broad Spectrum or Other Antibiotic Administration Time

Rationale: The Definition, Suggested Data Collection Question, and Allowable Values are being updated to remove intravenous route.

Description of Changes:
Definition, Suggested Data Collection Question
Change: administered intravenously if given
To: started

Impacts:
Broad Spectrum or Other Antibiotic Administration Time

Rationale: The Notes for Abstraction are being updated to include additional guidance to the abstractor.

Description of Changes:
Notes for Abstraction
Change to:
- Only IV antibiotic administered in the 24 hours prior to or 3 hours after severe sepsis presentation is acceptable.

  EXCEPTION:
  If there is documentation indicating IV access could not be established, antibiotics administered via intramuscular (IM) or intraosseous (IO) started in the 24 hours prior to or 3 hours after the severe sepsis presentation is acceptable.

- If one or more antibiotic was started within the 24 hours prior to presentation of severe sepsis, and none of those same antibiotics were started more than 24 hours prior to presentation, abstract the earliest dose started in the 24 hours prior to presentation of severe sepsis.
• If one or more antibiotics were administered within 24 hours prior to severe sepsis presentation, abstract the earliest date and time that antibiotic was started. This may be the same time as the time of presentation or may be a time before presentation. Do not review for antibiotic doses started more than 72 hours prior to severe sepsis presentation.

**Examples:**

<table>
<thead>
<tr>
<th>More than 24 hours Before Presentation (Max. lookback 72 hrs.)</th>
<th>24 hours Before Presentation</th>
<th>Severe Sepsis</th>
<th>3 Hours After Presentation</th>
<th>Antibiotic Dose to Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
<td>First dose of A</td>
</tr>
<tr>
<td>B</td>
<td>C</td>
<td>C</td>
<td></td>
<td>Antibiotic B</td>
</tr>
<tr>
<td>G</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>First dose of A</td>
</tr>
<tr>
<td>B</td>
<td>B</td>
<td>B</td>
<td></td>
<td>First dose of B</td>
</tr>
<tr>
<td>C</td>
<td>D</td>
<td>C</td>
<td>C</td>
<td>First dose of C</td>
</tr>
</tbody>
</table>

• If one or more antibiotic was started within the 3 hours after the presentation of severe sepsis, and the patient did not receive an antibiotic in the 24 hours before severe sepsis presentation, abstract the dose started closest to severe sepsis presentation.

**Examples:**

<table>
<thead>
<tr>
<th>More than 24 hours Before Presentation (Max. lookback 72 hrs. from presentation)</th>
<th>24 hours Before Presentation</th>
<th>Severe Sepsis</th>
<th>3 Hours After Presentation</th>
<th>Antibiotic Dose to Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td></td>
<td>L</td>
<td></td>
<td>Antibiotic L</td>
</tr>
<tr>
<td>K</td>
<td></td>
<td>K</td>
<td>A</td>
<td>Dose of K in 3 hr. period</td>
</tr>
</tbody>
</table>

• If antibiotics were administered both 24 hours prior to and within 3 hours after the time of presentation of severe sepsis, abstract the earliest date and time that an antibiotic in the 24 hours prior was started. This may be the same time as the time of presentation or may be a time before presentation. Do not review for antibiotic doses started more than 72 hours prior to severe sepsis presentation.

**Examples:**

<table>
<thead>
<tr>
<th>More than 24 hours Before Presentation (Max. lookback 72 hrs. from presentation)</th>
<th>24 hours Before Presentation</th>
<th>Severe Sepsis</th>
<th>3 Hours After Presentation</th>
<th>Antibiotic Dose to Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>D</td>
<td>D</td>
<td></td>
<td>First dose of D</td>
</tr>
<tr>
<td>E</td>
<td>F</td>
<td>F</td>
<td></td>
<td>Antibiotic E</td>
</tr>
<tr>
<td>E</td>
<td>E</td>
<td>E</td>
<td>L</td>
<td>First dose of E</td>
</tr>
<tr>
<td>M</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>First dose of A</td>
</tr>
<tr>
<td>M</td>
<td>A</td>
<td>B</td>
<td>M</td>
<td>First dose of A</td>
</tr>
</tbody>
</table>
• Stop abstracting 3 hours after the presentation of severe sepsis.
• If no antibiotic was started in the 24 hours before or 3 hours after the severe sepsis presentation, enter "UTD."
• Do not cross reference between different sources to infer that an antibiotic was started if it was documented only with name/date/time given but no route indicated. The route on the MAR for an antibiotic cannot be used as the route for a dose of the same antibiotic on another form.
• If the antibiotic name, route, date or time is missing, disregard that dose.
• Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of the specific antibiotic within the time window of 24 hours prior to or 3 hours following the presentation of severe sepsis.
  
  **Examples:**
  - A physician order for IV antibiotics is not sufficient unless the antibiotic ordered was marked as “given” with date/time noted.
  - Do not collect antibiotics documented on an operative report unless the surgeon states that the surgeon actually administered the dose.
• Specific documentation by one person that another person administered the antibiotic is acceptable for determining the date and time of administration.
  
  **Example:**
  OR nurse, S. Smith RN, documents, “Cefazolin 1 gm IV given on 1/7/20xx at 0500 per J Doe RN.” This dose can be abstracted as given if not documented by the person that gave the dose.
• The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as started. The methods may vary. Whatever method is used, it must be clear that the dose was administered.
• Do not abstract test doses of antibiotics.
• Do not abstract antibiotics from sources that do not represent actual administration.
  
  **Examples that do not represent actual administration:**
  Pre-Op Checklist states:
  - X IV Started at 1730
  - X Preop Antibiotic Given at 1800
  - X Lab on Chart
  Operative report states: IV antibiotics were given prior to procedure.
• Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was started during the specified timeframe.
  
  **Example:**
  Narrative states: “Ancef 1 gram given IV prior to incision.” No other doses of Ancef are documented. The dose in the narrative should be abstracted using “UTD” for missing data (no date and time).
• Pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record should be used for abstracting antibiotics.
Impacts:
*Broad Spectrum or Other Antibiotic Administration Selection*

**Rationale:** The Definition, Suggested Data Collection Question, and Allowable Values are being updated to remove intravenous route.

**Description of Changes:**
*Definition, Suggested Data Collection Question*

**Remove:**
Intravenous (IV)

**Allowable Values**

**Change from:**
1 (Yes) The IV antibiotic that was given within 3 hours following the presentation of severe sepsis is consistent with antibiotic selection guidelines.
2 (No) The IV antibiotic that was given within 3 hours following the presentation of severe sepsis is not consistent with antibiotic selection guidelines.

**To:**
1 (Yes) The antibiotic that was given within 3 hours following the presentation of severe sepsis is consistent with antibiotic selection guidelines.
2 (No) The antibiotic that was given within 3 hours following the presentation of severe sepsis is not consistent with antibiotic selection guidelines.

Impacts:
*Broad Spectrum or Other Antibiotic Administration Selection*

**Rationale:** The Notes for Abstraction are being updated to include additional guidance to the abstractor.

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

**Change to:**
- Only IV antibiotic administered 3 hours after severe sepsis presentation is acceptable.
  
  **EXCEPTION:**
  If there is documentation indicating IV access could not be established, antibiotics administered via intramuscular (IM) or intraosseous (IO) started 3 hours after the severe sepsis presentation is acceptable to select value “1.”

- Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of the antibiotic within the 3 hours following *Severe Sepsis Presentation Date and Time*.

- If there is one antibiotic started within 3 hours after presentation of severe sepsis that is on the monotherapy table in Appendix C, Table 5.0, choose Value “1.”

- If the administered antibiotics were NOT on Table 5.0, determine if the antibiotics are on Table 5.1 in Appendix C. Determine the class the administered antibiotics belong to, based on the class name in the shaded row above the antibiotic names. Next, refer to the following Combination Antibiotic Therapy Table to determine if an antibiotic from a class in both Column A and Column B were given. There must be at least one from a class in column A and at least one from a class in column B administered to select Value “1.” Review the chart to see that both drugs were started within 3 hours of severe...
sepsis presentation and if so, choose Value “1.” If both drugs were not started within 3 hours, choose Value “2.”

**Combination Antibiotic Therapy Table**

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aminoglycosides OR</td>
<td>Cephalosporins (1st and 2nd Generation) OR</td>
</tr>
<tr>
<td>Aztreonam OR</td>
<td>Clindamycin IV OR</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>Daptomycin OR</td>
</tr>
<tr>
<td></td>
<td>Glycopeptides OR</td>
</tr>
<tr>
<td></td>
<td>Linezolid OR</td>
</tr>
<tr>
<td></td>
<td>Macrolides OR</td>
</tr>
<tr>
<td></td>
<td>Penicillins</td>
</tr>
</tbody>
</table>

- If an antibiotic from Table 5.0 or an appropriate combination of antibiotics from Table 5.1 is not started or given within the 3 hours following presentation of severe sepsis, but there is a lab report or physician/APN/PA documentation indicating the causative organism and susceptibility is known (see exception for *C. difficile*) and an antibiotic identified as appropriate to treat the causative organism is given within 3 hours following presentation of severe sepsis, choose Value "1."
  o Cultures are not limited to blood cultures
  o If a causative organism with a susceptible antibiotic are used, the causative organism must be identified from cultures collected in the period 24 hours prior to the antibiotic being started, or within 3 hours following severe sepsis presentation. Cultures or documentation referring to cultures obtained outside of this time period should not be used.

- Exception for *C. difficile*: If the causative organism is identified as *C. difficile*, susceptibility testing is not required, and if the patient is receiving oral vancomycin with or without oral or IV metronidazole (Flagyl), choose Value “1.”
  o Cultures are not limited to blood cultures
  o C-diff must be identified from cultures collected in the period 24 hours prior to the antibiotic being started, or within 3 hours following severe sepsis presentation. Cultures or documentation referring to cultures obtained outside of this time period should not be used.

**Impacts:**

**Capillary Refill Examination Date**

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**

**Suggested Data Collection Question**

**Change** to:

On what date was a capillary refill examination documented by a physician/APN/PA?

**Impacts:**

**Capillary Refill Examination Date**

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.
Description of Changes:
Notes for Abstraction
Change first bullet point to:
• Physician/APN/PA documentation must occur or reflect the assessment was performed between Crystallloid Fluid Administration Date, Crystallloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.

Change third bullet point to:
• If there are multiple capillary refill examinations performed, abstract the date of the latest measurement documented within the allowable time window.

Impacts:
Capillary Refill Examination Performed
Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
Was a capillary refill examination documented by a physician/APN/PA?

Impacts:
Capillary Refill Examination Performed
Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to determine if the assessment was performed.

Description of Changes:
Notes for Abstraction
Change to:
• Physician/APN/PA documentation must occur or reflect the assessment was performed between Crystallloid Fluid Administration Date, Crystallloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.
• Capillary refill examination can be documented by any one of the following 3 ways:
  o Physician/APN/PA documentation of an inclusion term.
    Example: Physician/APN/PA documentation of “capillary refill less than 3 seconds” would be sufficient.
  o Physician/APN/PA documentation that a capillary refill exam was reviewed, performed, or attested to reviewing or performing.
    Example: Physician/APN/PA documents “nurses capillary refill exam reviewed” would be sufficient.
  o Physician/APN/PA documentation of performing or attesting to performing a physical exam, perfusion (re-perfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam.
    Example: Physician/APN/PA documents “sepsis exam done.”
  A title or heading of a form, section, or assessment should not be used.
Example:
In the H&P there is a heading called “physical exam.”

- If there are no capillary refill examinations documented or documentation reflects the assessment was not performed in the allowable time window, choose Value “2.”
- If the capillary refill examination is in a physician/APN/PA note without a specific time, use the time the note was started or opened.

Impacts:
Capillary Refill Examination Time

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
At what time was a capillary refill examination documented by a physician/APN/PA?

Impacts:
Capillary Refill Examination Time

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

Description of Changes:
Notes for Abstraction
Change first bullet point to:
- Physician/APN/PA documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.

Change third bullet point to:
- If there are multiple capillary refill examinations performed, abstract the time of the latest measurement documented within the allowable time window.

Impacts:
Cardiopulmonary Evaluation Date

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
On what date was a cardiopulmonary evaluation documented by a physician/APN/PA?

Impacts:
Cardiopulmonary Evaluation Date

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.
Description of Changes:
Notes for Abstraction
Change first bullet point to:
• Physician/APN/PA documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.

Change third bullet point to:
• If there are multiple cardiopulmonary evaluations performed, abstract the date of the latest measurement documented within the allowable time window.

Impacts:
Cardiopulmonary Evaluation Performed
Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
Was a cardiopulmonary evaluation documented by a physician/APN/PA?

Impacts:
Cardiopulmonary Evaluation Performed
Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to determine if the assessment was performed.

Description of Changes:
Notes for Abstraction
Change to:
• Physician/APN/PA documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.
• Cardiopulmonary evaluation can be documented by any one of the following 3 ways:
  o Physician/APN/PA documentation must reference the heart, lungs and the findings.
    Example:
    Physician/APN/PA documents “Lungs clear, heart within normal limits.”
  o Physician/APN/PA documentation that a cardiopulmonary evaluation was reviewed, performed, or attested to reviewing or performing.
    • Referencing the heart, lungs and the findings are not required.
    Example:
    Physician/APN/PA documents “Reviewed and agree with the nurse’s cardiopulmonary assessment.”
  o Physician/APN/PA documentation of performing or attesting to performing a physical exam, perfusion (re-perfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam.
    Example:
    Physician/APN/PA documents “sepsis exam done.”
A title or heading of a form, section, or assessment should not be used.

**Example:**
In the H&P there is a heading called “physical exam.”

- If there are no cardiopulmonary evaluations documented or documentation reflects the assessment was not in the allowable time window, choose Value “2.”
- If cardiopulmonary evaluation is in a physician/APN/PA note without a specific time, use the time the note was started or opened.

### Impacts:
**Cardiopulmonary Evaluation Time**

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**
**Suggested Data Collection Question**
**Change** to:
At what time was a cardiopulmonary evaluation documented by a physician/APN/PA?

### Impacts:
**Cardiopulmonary Evaluation Time**

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

**Description of Changes:**
**Notes for Abstraction**
**Change** first bullet point to:
- Physician/APN/PA documentation must occur or reflect the assessment was performed between **Crystalloid Fluid Administration Date**, **Crystalloid Fluid Administration Time** and six hours after **Septic Shock Presentation Date**, **Septic Shock Presentation Time**.

**Change** third bullet point to:
- If there are multiple cardiopulmonary evaluations performed, abstract the time of the latest measurement documented within the allowable time window.

### Impacts:
**Central Venous Oxygen Measurement**

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**
**Suggested Data Collection Question**
**Change** to:
Was a central venous oxygen measurement obtained?

### Impacts:
**Central Venous Oxygen Measurement**

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to abstract if an assessment was not performed.
Description of Changes:
Notes for Abstraction
Change first bullet point to:
• Documentation must occur or reflect the assessment was performed between
  Crystallloid Fluid Administration Date, Crystallloid Fluid Administration Time and six
  hours after Septic Shock Presentation Date, Septic Shock Presentation Time.
Remove second bullet point:
• If there are multiple central venous oxygen measurements documented in the time
  window beginning at the crystalloid fluid administration date and time and ending six
  hours after the presentation of septic shock date and time, abstract the date and time of
  the measurement that was documented latest within the time window.
Change last bullet point to:
• If there are no central venous oxygen measurements documented or documentation
  reflects the assessment was not performed in the allowable time window, choose Value
  “2.”

Impacts:
Central Venous Oxygen Measurement Date

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction
burden.

Description of Changes:
Suggested Data Collection Question
Change to:
What was the date on which the central venous oxygen measurement was obtained?

Impacts:
Central Venous Oxygen Measurement Date

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and
how to address if there are multiple assessments performed.

Description of Changes:
Notes for Abstraction
Change first bullet point to:
• Documentation must occur or reflect the assessment was performed between
  Crystallloid Fluid Administration Date, Crystallloid Fluid Administration Time and six
  hours after Septic Shock Presentation Date, Septic Shock Presentation Time.
Add new second bullet point:
• If there are multiple central venous oxygen measurements performed, abstract the date
  of the latest measurement documented within the allowable time window.

Impacts:
Central Venous Oxygen Measurement Time

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction
burden.
Description of Changes:
Suggested Data Collection Question
Change to:
What was the time at which a central venous oxygen measurement was obtained?

Impacts:
Central Venous Oxygen Measurement Time
Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

Description of Changes:
Notes for Abstraction
Change first bullet point to:
• Documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.

Add new second bullet point:
• If there are multiple central venous oxygen measurements performed, abstract the time of the latest measurement documented within the allowable time window.

Impacts:
Central Venous Pressure Measurement
Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
Was a central venous pressure measurement obtained?

Impacts:
Central Venous Pressure Measurement
Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to abstract if an assessment was not performed.

Description of Changes:
Notes for Abstraction
Change first bullet point to:
• Documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.

Remove second bullet point:
• If there are multiple central venous pressure measurements documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date and time of the measurement that was documented latest within the time window.
Change last bullet point to:

- If there are no central venous pressure measurements documented or documentation reflects the assessment was not performed in the allowable time window, choose Value “2.”

**Impacts:**
*Central Venous Pressure Measurement Date*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**
*Suggested Data Collection Question*

**Change** to:
What was the date on which a central venous pressure measurement was obtained?

**Impacts:**
*Central Venous Pressure Measurement Date*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

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

**Change** to:
- Documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date*, *Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.
- If there are multiple central venous pressure measurements performed, abstract the date of the latest measurement documented within the allowable time window.
- Central Venous Pressure measurement may be expressed as CVP, central venous pressure, or RAP, right atrial pressure.

**Impacts:**
*Central Venous Pressure Measurement Time*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**
*Suggested Data Collection Question*

**Change** to:
What was the time at which a central venous pressure measurement obtained?

**Impacts:**
*Central Venous Pressure Measurement Time*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.
**Description of Changes:**

**Notes for Abstraction**

**Change to:**
- Documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date*, *Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.
- If there are multiple central venous pressure measurements performed, abstract the time of the latest measurement documented within the allowable time window.
- Central Venous Pressure measurement may be expressed as CVP, central venous pressure, or RAP, right atrial pressure.

**Impacts:**

*Clinical Trial*

**Rationale:** The measure is being revised to exclude patients that are enrolled in a clinical trial related to sepsis care and management.

**Description of Changes:**

**Index**

**Add:**

*SEP-1 in Collected For column for Clinical Trial.*

**Collected For**

**Add:**

*Collected For CMS Only: SEP-1*

**Change throughout data element (i.e., VTE)**

**To:**

(i.e., VTE or SEP-1)

**Add** new section after ‘VTE’ section:

**SEP-1:**

Only capture patients enrolled in clinical trials studying patients with sepsis, severe sepsis or septic shock (treatment and interventions).

**Impacts:**

*Crystalloid Fluid Administration*

**Rationale:** The Notes for Abstraction are being revised to list acceptable electrolytes that may be added to crystalloid fluids to satisfy the 30 mL/kg infusion requirement.

**Description of Changes:**

**Notes for Abstraction**

**Add** new second bullet point:

- Crystalloid fluid volumes to which the following electrolytes have been added may be counted toward the 30 mL/kg requirement: potassium, magnesium, calcium, lactate, acetate, or gluconate.

**Impacts:**

*Crystalloid Fluid Administration*

**Rationale:** The Allowable Values were updated to clarify the target ordered volume.
Description of Changes:

Allowable Values:

**Change from:**

1 (Yes)  30 mL/kg of crystalloid fluids were ordered and 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*, and 30 mL/kg of crystalloid fluids were infused.

2 (No)  Less than 30 mL/kg of crystalloid fluids were ordered and 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 volume ordered, or less than 30 mL/kg of crystalloid fluids were infused.

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).

**To:**

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.

**Impacts:**

**Crystalloid Fluid Administration**

**Rationale:** The Notes for Abstraction are being updated to provide guidance and decrease abstraction burden.

**Description of Changes:**

**Notes for Abstraction**

**Change to:**

- 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.
- Crystalloid fluid volumes ordered that are within 10% lower than the 30 mL/kg total volume calculated by weight are acceptable.

**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.

- Acceptable fluids are crystalloid or balanced crystalloid solutions.
- 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.
- Only abstract crystalloid fluids started for the presence of Initial Hypotension, OR for the presence of an Initial Lactate Level Result >=4 mmol/L, OR physician/APN/PA Documentation of Septic Shock.
- Do not abstract crystalloid fluids started more than 6 hours prior to the presence of an Initial Lactate Level Result >=4 mmol/L or physician/APN/PA Documentation of Septic Shock.
- For the presence of Initial Hypotension, only abstract crystalloid fluids that were started in the timeframe of 6 hours prior through 3 hours after the initial hypotension.
  - A single order for the target ordered volume initiated within 6 hours prior through 3 hours after initial hypotension is acceptable.
  - If crystalloid fluids are initiated via multiple physician/APN/PA orders, only abstract crystalloid fluids initiated within 6 hours prior through 3 hours after.
- 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 orders.

  **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.

- Use the weight documented closest to and prior to the order for crystalloid fluids. If a weight is not documented prior to the crystalloid fluid order, use the weight recorded closest to and after the crystalloid fluid order.
- Use the patient’s actual weight. Use estimated weight only if actual weight is not available to determine the volume of crystalloid fluids the patient should receive. Do not use ideal weight unless indicated by the physician/APN/PA.
- If there is physician/APN/PA documentation identifying the patient has obesity (defined as a Body Mass Index > 30), the clinician may choose to use Ideal Body Weight (IBW) to determine the target ordered crystalloid fluid volume. If the clinician prefers to use IBW, it must be documented clearly and the clinician must indicate that IBW will be the weight used to determine the target ordered volume.
- 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 the total volume of crystalloid fluids ordered is less than the target ordered volume, select Value “2.”
- **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 (written in the order or documented by nursing):
  - 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 an infusion rate, duration, or time over which the IV fluids are to be given is not written in the order or not documented by nursing OR a fluid bolus completed time or end time is not documented, do not use the fluids toward the target ordered volume.
- If an ordered rate or duration time frame to infuse fluids and the rate or duration time frame the fluids were actually administered over are different, use the rate or duration time the fluids were actually administered over.
• If crystalloid fluids are only given at 125 mL/hour or less, at a maintenance rate or at a “Keep Vein Open” (KVO) rate, choose Value “2.”
• Only those crystalloid fluids given at a rate greater than 125 mL/hour should be used towards the target ordered volume.
• If there is documentation the infusion was stopped prior to reaching the target ordered volume, select Value “2.”
• 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:**
*Crystalloid Fluid Administration*

**Rationale:** The Inclusion Guidelines for Abstraction and Exclusion Guidelines for Abstraction were revised to reflect other types of crystalloid fluids that can be used towards the target ordered volume.

**Description of Changes:**

**Inclusion Guidelines for Abstraction**

**Remove:**
ONLY ACCEPTABLE CRYSTALLOID FLUIDS

**Add:**
• Isoleyte

**Exclusion Guidelines for Abstraction**

**Change** to:
Crystalloid solutions that are given to flush other medications or IV lines

**Impacts:**
*Crystalloid Fluid Administration Date*

**Rationale:** The Notes for Abstraction are being updated to provide guidance and decrease abstraction burden.

**Description of Changes:**

**Notes for Abstraction:**

**Change** to:
• 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.
• If a single order is written for the target ordered volume, use the date the crystalloid solution was started as an IV infusion.
• If a single order is written for the target ordered volume and the infusion is given over multiple infusions, use the start date of the first crystalloid fluid infusion.
• If multiple orders are written that total the target ordered volume, use the start date of the crystalloid fluid infusion that completes the target ordered volume.
• If a crystalloid infusion is running at a maintenance rate (125 mL/hour or less) and the rate is increased to administer the target ordered volume, use the date the infusion rate is increased.

• In some cases, the crystalloid fluid will be infusing prior to the time of presentation of Initial Hypotension, an Initial Lactate Level Result \(>=4\) mmol/L, or physician/APN/PA Documentation of Septic Shock; if so, use the date the unit of fluid was started or hung.

Examples:

  o Initial hypotension was present on 07-12-20xx at 14:00. Prior to the initial hypotension, one liter of Lactated Ringers had been hung at 13:00 on 07-12-20xx. The Crystalloid Fluid Administration Date was 07-12-20xx.
  
  o An initial lactate of 4.5 was drawn on 07-12-20xx at 14:00. Normal Saline was started on 07-12-20xx at 12:00 – there was no fluid infusing at the date and time the initial lactate was drawn. The Crystalloid Fluid Administration Date was 07-12-20xx.
  
  o Persistent hypotension was present on 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 3000 mL of 0.9% Normal Saline over 2 hours is written. The total volume is given as 3 separate infusions of 1000 mL each. The first of the three infusions is started on 08-14-20xx at 22:00. The Crystalloid Fluid Administration Date was 08-14-20xx.
  
  o Septic shock presentation date and time was 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 1000 mL of 0.9% Normal Saline over 60 minutes is written and started on 08-14-20xx at 22:00. An order for another 1000 mL of Normal Saline is written and started on 08-14-20xx at 23:15. A third order for 1000 mL of Normal Saline is written and started on 08-15-20xx at 00:30. The Crystalloid Fluid Administration Date was 08-15-20xx.

• Do not abstract the date that fluids were ordered or the date that IV access was started. Abstract the date that the crystalloid fluid infusion began.

• Do not use physician orders as fluid administration start date and time; use the date and time that the fluid infusion was initiated.

• 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 rate, duration, or end time of the fluid infusion. A physician/APN/PA order for fluids administered prior to arrival is not required.

Impacts:

Crystalloid Fluid Administration Time

Rationale: The Notes for Abstraction are being updated to provide guidance and decrease abstraction burden.

Description of Changes:

Notes for Abstraction

Change to:

• 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.
• If a single order is written for the target ordered volume, use the time the crystalloid solution was started as an IV infusion.
• If a single order is written for the target ordered volume and the infusion is given over multiple infusions, use the start time of the first crystalloid fluid infusion.
• If multiple orders are written that total the target ordered volume, use the start time of the crystalloid fluid infusion that completes the target ordered volume.
• If a crystalloid infusion is running at a maintenance rate (125 mL/hour or less) and the rate is increased to administer the target ordered volume, use the time the infusion rate is increased.
• In some cases, the crystalloid fluid will be infusing prior to the time of presentation of Initial Hypotension, an Initial Lactate Level Result >=4 mmol/L, or physician/APN/PA Documentation of Septic Shock; if so, use the time the unit of fluid was started or hung.

Examples:
  o Initial hypotension was present on 07-12-20xx at 14:00. Prior to the initial hypotension, one liter of Lactated Ringers had been hung at 13:00 on 07-12-20xx. The Crystalloid Fluid Administration Time was 13:00.
  o An initial lactate of 4.5 was drawn on 07-12-20xx at 14:00. Normal Saline was started on 07-12-20xx at 12:00 – there was no fluid infusing at the date and time the initial lactate was drawn. The Crystalloid Fluid Administration Time was 12:00.
  o Persistent hypotension was present on 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 3000 mL of 0.9% Normal Saline over 2 hours is written. The total volume is given as 3 separate infusions of 1000 mL each. The first of the three infusions was started on 08-14-20xx at 22:00. The Crystalloid Fluid Administration Time was 22:00.
  o Septic shock presentation date and time was 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 1000 mL of Normal Saline over 60 minutes is written and started on 08-14-20xx at 22:00. An order for another 1000 mL of Normal Saline is written and started on 08-14-20xx at 23:15. A third order for 1000 mL of Normal Saline is written and started on 08-15-20xx at 00:30. The Crystalloid Fluid Administration Time was 00:30.

• Do not abstract the time that fluids were ordered or the time that IV access was started. Abstract the time that the crystalloid fluid infusion began.
• Do not use physician orders as fluid administration start date and time, use the date and time that the fluid infusion was initiated.
• 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 rate, duration, or end time of the fluid infusion. A physician/APN/PA order for fluids administered prior to arrival is not required.

Impacts:
Directive for Comfort Care or Palliative Care, Septic Shock

Rationale: The Notes for Abstraction are being updated to provide guidance and decrease abstraction burden.
Description of Changes:
Notes for Abstraction

Change second bullet point to:
- The earliest physician/APN/PA documentation of an inclusion term mentioned in the following contexts suffices:
  - Comfort measures only recommendation
  - Order for consultation or evaluation by a hospice care service
  - Patient or patient representative request for comfort measures only
  - Plan for comfort measures only
  - Referral to hospice care service

Remove third bullet point:
- Determine the earliest documentation of comfort measures only or palliative care by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select Value “1.”
  
  **Example:**
  “Plan for consultation with hospice care” noted in progress note prior to onset of septic shock – Select “1.”

Change fourth bullet point, fifth sub-bullet point to:
- For cases where there is a SAPO in the record with a CMO option selected: If the SAPO is dated prior to arrival and there is documentation on the day of arrival up to septic shock presentation that the patient or patient representative does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.

Impacts:
**Directive for Comfort Care or Palliative Care, Severe Sepsis**

Rationale: The data element is being updated to expand the timeframe for documentation of comfort measures only or palliative care when severe sepsis is present.

Description of Changes:
Allowable Values

**Change** from:

1 (Yes)  
Physician/APN/PA documentation of comfort measures only or palliative care was prior to or within 3 hours of the presentation of severe sepsis.

2 (No)  
Physician/APN/PA documentation of comfort measures only or palliative care was not prior to or within 3 hours of presentation of severe sepsis, or not documented or time is unclear.

**To:**

1 (Yes)  
Physician/APN/PA documentation of comfort measures only or palliative care was prior to or within 6 hours of the presentation of severe sepsis.

2 (No)  
Physician/APN/PA documentation of comfort measures only or palliative care was not prior to or within 6 hours of presentation of severe sepsis, or not documented or time is unclear.
Impacts:
*Directive for Comfort Care or Palliative Care, Severe Sepsis*

Rationale: The Notes for Abstraction are being updated to provide abstraction clarification for documentation of comfort measures only or palliative care.

Description of Changes:
Notes for Abstraction:

**Change** second bullet point to:
- The earliest physician/APN/PA documentation of an inclusion term mentioned in the following contexts suffices:
  - Comfort measures only recommendation
  - Order for consultation or evaluation by a hospice care service
  - Patient or patient representative request for comfort measures only
  - Plan for comfort measures only
  - Referral to hospice care service

**Remove** third bullet point:
- Determine the earliest documentation of comfort measures only or palliative care by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select Value “1.”
  
  **Example:**
  “Plan for consultation with hospice care" noted in progress note prior to onset of septic shock – Select “1.”

**Change** fourth bullet point, fifth sub-bullet point to:
- For cases where there is a SAPO in the record with a CMO option selected: If the SAPO is dated prior to arrival and there is documentation on the day of arrival up to severe sepsis presentation that the patient or patient representative does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.

Impacts:
*Discharge Disposition*

Rationale: Effective January 1, 2018, the SUB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

Description of Changes:
Index

**Remove** SUB-4 and TOB-4 under ‘Collected For’ for the data element Discharge Disposition

**Data Element**

**Remove** from Collected For:
- CMS/The Joint Commission: SUB-4, TOB-4 data collection suspended

Impacts:
*Discharge Time*

Rationale: The Notes for Abstraction are being updated to provide guidance and decrease abstraction burden.
Description of Changes:
Notes for Abstraction

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

  Example:
  Documentation indicates the patient expired at 3300. No other documentation in the medical record provides a valid time. Since the Time Expired is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”

Add new fourth bullet point:
• If the patient expired and there is not a pronounced time but there is a discharge time, use the discharge time.

Change last bullet point to:
• If there are multiple times documented when the patient was discharged, use the earliest time.

Impacts:
Discharge Time

Rationale: The Guidelines for Abstraction are being updated to make the Inclusion and Exclusion section consistent with other data elements.

Description of Changes:
Guidelines for Abstraction
Change to:
Inclusion Guidelines for Abstraction:
None
Exclusion Guidelines for Abstraction:
None

Impacts:
Fluid Challenge Date

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
On what date was a fluid challenge performed?

Impacts:
Fluid Challenge Date

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.
Description of Changes:
Notes for Abstraction
Change to:
- Documentation must occur or reflect the assessment was performed between the completion of the crystalloid fluids and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.
- If there are multiple fluid challenges performed, abstract the latest fluid challenge done within the allowable time window.
- Abstract the date and time the fluid challenge was initiated or started. Do not abstract when the IV line was started or when the order for fluid challenge was received.
- If a physician/APN/PA note documents “fluid challenge infused” or “fluid challenge completed,” or similar terms indicating that a fluid challenge was done, consult the IV therapy record to determine the date the infusion was begun.

Impacts:
*Fluid Challenge Performed*

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
Was a fluid challenge performed?

Impacts:
*Fluid Challenge Performed*

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to determine if the assessment was performed.

Description of Changes:
Notes for Abstraction
Change to:
- Documentation must occur or reflect the assessment was performed between the completion of the crystalloid fluid administration and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.
- A fluid challenge is done after the target ordered volume (30 mL/kg or up to 10% less than 30 mL/kg) of crystalloid fluid is administered.
- Refer to the *Crystalloid Fluid Administration* data element for acceptable crystalloid fluids.
- A fluid challenge could be documented **any one of the following 3 ways** and requires a review of the IV fluid administration record to determine if a physician/APN/PA order or physician/APN/PA documentation of a fluid challenge was carried out.
  - An order including one of the terms in the Inclusion Guidelines for Abstraction or a similar term and identifies the IV fluid, volume, and time to infuse.
  - An order for 500mL-1000 mL to be given over 15 to 30 minutes.
  - Physician/APN/PA documentation of “fluid challenge infused” or “fluid challenge completed,” or similar terms indicating that a fluid challenge was done.
If there are no fluid challenges documented or documentation reflects the assessment was not performed in the allowable time window, choose Value “2.”

**Impacts:**
*Fluid Challenge Time*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**
*Suggested Data Collection Question*

**Change to:**
At what time was a fluid challenge performed?

**Impacts:**
*Fluid Challenge Time*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

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

**Change to:**
- Documentation must occur or reflect the assessment was performed between the completion of the crystalloid fluids and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.
- If there are multiple fluid challenges performed, abstract the latest fluid challenge done within the allowable time window.
- Abstract the date and time the fluid challenge was initiated or started. Do not abstract when the IV line was started or when the order for fluid challenge was received.
- If a physician/APN/PA note documents “fluid challenge infused” or “fluid challenge completed,” or similar terms indicating that a fluid challenge was done, consult the IV therapy record to determine the time the infusion was begun.

**Impacts:**
*Initial Hypotension*

**Rationale:** The Definition was updated to provide guidance and decrease abstraction burden.

**Description of Changes:**
*Definition*

**Change to:**
Documentation of the presence of initial hypotension 6 hours prior to or within 6 hours following *Severe Sepsis Presentation Date and Time* 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.

**Impacts:**
*Initial Hypotension*

**Rationale:** The Allowable Values were updated to provide guidance and decrease abstraction burden.
Description of Changes:

Allowable Values

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

To:
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.

Impacts:
Initial Hypotension

Rationale: The Notes for Abstraction are being updated to provide guidance and decrease abstraction burden.

Description of Changes:
Notes for Abstraction

Change to:
• The criteria for determining that Initial Hypotension was present are as follows:
  o Either 6 hours prior to or within 6 hours following Severe Sepsis presentation of two low blood pressure readings from different measurements of either:
    ▪ 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.
  
• If there is physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time indicating hypotension or low blood pressure (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it should not be used. Inferences should not be made.
  o It is required that the same physician/APN/PA documentation must also include either the abnormal value or reference the abnormal value.
    ▪ Normal for that patient
    ▪ Is due to a chronic condition
    ▪ Is due to a medication
  
• If there is physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time indicating hypotension or low blood pressure (SBP <90 mmHg or MAP <65 mmHg) is due to the following, the criteria value should be used.
  o Acute condition
  o Acute injury on a chronic condition

Example:
Hypotension due to acute exacerbation on chronic heart failure

• If there is physician/APN/PA documentation prior to or within 24 hours of Severe Sepsis Presentation Time indicating the acute condition is due to a non-infectious
source/process, it should not be used (Refer to Severe Sepsis Present to determine if a condition is an infection).

**Examples:**
- Hypotension due to acute blood loss secondary to trauma.
- Hypotension due to acute exacerbation on chronic heart failure due to worsening heart failure.

- 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 there is physician/APN/PA or nursing documentation indicating a low blood pressure reading is invalid, erroneous or questionable, disregard that reading when determining the presence of initial hypotension.
- Blood pressure readings documented in the operating room (OR) should not be used.
- Do not use low BPs documented from an orthostatic BP evaluation.
- 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 low blood pressure(s) recorded, the low blood pressure value(s) should not be used. The documentation must be within 24 hours following the low blood pressure value(s).

**Impacts:**
*Initial Lactate Level Result*

**Rationale:** A bullet point is being added to provide additional guidance to the abstractor.

**Description of Changes:**

**Notes for Abstraction**

**Add** fourth bullet point:
- If point of care (POC) results and laboratory results are obtained from the same sample, use the results that are recorded first.

**Add** fifth bullet point:
- If there is physician/APN/PA documentation prior to or within 24 hours after the initial lactate level result that indicates the initial lactate value is due to a condition that is not an infection, or is due to a medication, select Value “1.”

**Impacts:**
*Passive Leg Raise Exam Date*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**

**Suggested Data Collection Question**

**Change** to:
On what date was a passive leg raise examination documented?
Impacts:
Passive Leg Raise Exam Date

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

Description of Changes:
Notes for Abstraction
Change to:
• Documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.
• If there are multiple passive leg raise exams performed, abstract the date and time of the latest measurement documented within the allowable time window.
• Only abstract documentation indicating actual performance of a passive leg raise exam.

Impacts:
Passive Leg Raise Exam Performed

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
Was there documentation that a passive leg raise examination was performed?

Impacts:
Passive Leg Raise Exam Performed

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to abstract if an assessment was not performed.

Description of Changes:
Notes for Abstraction
Change to:
• Documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.
• Passive leg raise examination may be referred to in alternate terms as PLR or leg raise and is commonly noted to be either positive or negative. With the patient in a semi-recumbent position, both legs are raised to a 45 degree angle to evaluate the vital sign response to additional fluid load.
• If there are no passive leg raise examinations documented or documentation reflects the assessment was not performed in the allowable time window, choose Value “2.”
Impacts:  
*Passive Leg Raise Exam Time*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**  
**Suggested Data Collection Question**  
**Change to:**  
At what time was a passive leg raise examination documented?

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Impacts:  
*Passive Leg Raise Exam Time*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

**Description of Changes:**  
**Notes for Abstraction**  
**Change to:**  
- Documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date, Septic Shock Presentation Time*.
- If there are multiple passive leg raise exams performed, abstract the date and time of the latest measurement documented within the allowable time window.
- Only abstract documentation indicating actual performance of a passive leg raise exam.

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Impacts:  
*Patient HIC#*

**Rationale:** The data element *Patient HIC#* is being deleted as it is not used by CMS in the abstraction process and may contain the patients Social Security Number.

**Description of Changes:**  
**Remove** in Index and Data Dictionary in its entirety:  
*Patient HIC#*

---

Impacts:  
*Peripheral Pulse Evaluation Date*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**  
**Suggested Data Collection Question**  
**Change to:**  
On what date was a peripheral pulse evaluation documented by a physician/APN/PA?

---

Impacts:  
*Peripheral Pulse Evaluation Date*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.
Description of Changes:
Notes for Abstraction

Change first bullet point to:
- Physician/APN/PA documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.

Change third bullet point to:
- If there are multiple peripheral pulse evaluations performed, abstract the date of the latest measurement documented within the allowable time window.

Impacts:
Peripheral Pulse Evaluation Performed

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
Was a peripheral pulse evaluation documented by a physician/APN/PA?

Impacts:
Peripheral Pulse Evaluation Performed

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to determine if the assessment was performed.

Description of Changes:
Notes for Abstraction
Change to:
- Physician/APN/PA documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.
- Peripheral pulse evaluation can be documented by any one of the following 3 ways:
  - Physician/APN/PA documentation of an inclusion term or similar terms that reference peripheral pulses.
    **Example:**
    Physician/APN/PA documentation of "pulses present in all extremities"
  - Physician/APN/PA documentation that a peripheral pulse evaluation was reviewed, performed, or attested to reviewing or performing.
    **Example:**
    Physician/APN/PA documents "Agree with nurse’s peripheral pulse assessment"
  - Physician/APN/PA documentation of performing or attesting to performing a physical exam, perfusion (re-perfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam.
    **Example:**
    Physician/APN/PA documents “sepsis exam done.”
• A title or heading of a form, section, or assessment should not be used.
  
  **Example:**
  In the H&P there is a heading called “physical exam.”

• If there are no peripheral pulse evaluations documented or documentation reflects the assessment was not performed in the allowable time window, choose Value “2.”

• If the peripheral pulse evaluation is in a physician/APN/PA note without a specific time, use the time the note was started or opened.

**Impacts:**
*Peripheral Pulse Evaluation Time*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**
*Suggested Data Collection Question*

**Change** to:
At what time was a peripheral pulse evaluation documented by a physician/APN/PA?

**Impacts:**
*Peripheral Pulse Evaluation Time*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

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

**Change** first bullet point to:
- Physician/APN/PA documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date*, *Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.

**Change** third bullet point to:
- If there are multiple peripheral pulse evaluations performed, abstract the time of the latest measurement documented within the allowable time window.

**Impacts:**
*Persistent Hypotension*

**Rationale:** The Definition was updated to provide guidance and decrease abstraction burden.

**Description of Changes:**
*Definition*

**Change** to:
Documentation of the presence of persistent hypotension or new onset of hypotension following the administration of the target ordered volume (30 mL/kg or up to 10% less than 30 mL/kg) of crystalloid fluids.

**Impacts:**
*Persistent Hypotension*

**Rationale:** The Allowable Values and Notes for Abstraction were changed to reflect the target ordered volume.
Description of Changes:

Allowable Values

Change from:

1 (Yes) Crystalloid fluids were administered at a volume of 30 mL/kg and persistent hypotension or new onset of hypotension was present within one hour of conclusion of fluid administration.

2 (No) Persistent hypotension or new onset of hypotension was not present within one hour of the conclusion of crystalloid fluid administration at a volume of 30 mL/kg.

3 (No) or UTD The patient was not assessed for persistent hypotension or new onset of hypotension within the one hour after the conclusion of crystalloid fluid administration at a volume of 30 mL/kg, or Unable to Determine.

4 (Not applicable) Crystalloid fluids were administered but at a volume less than 30 mL/kg.

To:

1 (Yes) Persistent hypotension or new onset of hypotension was present within one hour of conclusion of crystalloid fluid administration at the target ordered volume.

2 (No) Persistent hypotension or new onset of hypotension was not present within one hour of the conclusion of crystalloid fluid administration at the target ordered volume.

3 (No) or UTD The patient was not assessed for persistent hypotension or new onset of hypotension within one hour after the conclusion of crystalloid fluid administration at the target ordered volume, or Unable to Determine.

4 (Not applicable) Crystalloid fluids were administered but at a volume less than the target ordered volume.

Impacts:

Persistent Hypotension

Rationale: The Notes for Abstraction are being updated to provide guidance and decrease abstraction burden.

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.
- 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 is more than one blood pressure documented, refer to the last two 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.”

If there is physician/APN/PA documentation prior to or within 24 hours after **Severe Sepsis Presentation Time** indicating hypotension or low blood pressure (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it should not be used. Inferences should not be made.

- It is required that the same physician/APN/PA documentation must also include either the abnormal value or reference the abnormal value.
  - Normal for that patient
  - Is due to a chronic condition
  - Is due to a medication

If there is physician/APN/PA documentation prior to or within 24 hours after **Severe Sepsis Presentation Time** indicating hypotension or low blood pressure (SBP <90 mmHg or MAP <65 mmHg) is due to the following, the criteria value should be used.

- Acute condition
- Acute injury on a chronic condition

**Example:**
Hypotension due to acute exacerbation on chronic heart failure.

**Examples:**
- Hypotension due to acute blood loss secondary to trauma.
- Hypotension due to acute exacerbation of chronic heart failure due to worsening heart failure.

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.”
- Blood pressure readings documented in the operating room (OR) should not be used.
- 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 there is physician/APN/PA or nursing documentation indicating a low blood pressure reading is erroneous or questioning the validity of a low blood pressure reading, do not consider that reading for determining the presence of persistent or new onset of hypotension.
Impacts:
Prescription for Tobacco Cessation Medication
Referral for Outpatient Tobacco Cessation Counseling
Tobacco Use Status

Rationale: Effective January 1, 2018, the TOB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

Description of Changes:
Index
Remove TOB-4 under ‘Collected For’

Data Element
Remove from Collected For The Joint Commission Only:
TOB-4 data collection suspended

Impacts:
Reason for No Tobacco Cessation Medication at Discharge

Rationale: The data element is being updated to provide abstraction guidance.

Description of Changes:
Notes for Abstraction
Change fourth bullet point to:
• When conflicting information is documented in the medical record, select Value “No.”

Impacts:
Referral for Addictions Treatment

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

Description of Changes:
Definition
Change second sentence to:
A referral is defined as an appointment made by the provider either through telephone contact, fax or e-mail.

Allowable Value 5
Change from:
5 The referral for addictions treatment was not offered at discharge or unable to determine from the medical record documentation.

To:
5 The referral for addictions treatment was not offered at any time prior to discharge or unable to determine from the medical record documentation.

Notes for Abstraction
Change first bullet to:
• A referral to Alcoholics Anonymous (AA) or similar mutual support groups does not meet the intent of the measure, select Value “5” if such a referral is given to the patient.
Impacts:
Referral for Outpatient Tobacco Cessation Counseling

Rationale: This data element is being updated to provide abstraction guidance.

Description of Changes:
Notes for Abstraction
Change last two bullet points to:
- If the patient refused practical counseling (Tobacco Use Treatment Practical Counseling) during the hospitalization, a referral for outpatient tobacco cessation counseling must still be offered at the time of discharge. Select Value “5” if a referral for outpatient counseling was not offered at the time of discharge.
- If outpatient tobacco cessation counseling was offered during the hospitalization and the patient refused, select Value “3.” It does not need to be offered again at discharge.

Impacts:
Septic Shock Present

Rationale: The Septic Shock Present data element is being updated to provide additional guidance.

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.
- 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
     AND
     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
     AND
     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.
• Use the time vital signs were taken or obtained. If time taken or obtained is not available, use recorded or documented time.

• If there is physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time indicating hypotension or low blood pressure (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it should not be used. Inferences should not be made.
  o It is required that the same physician/APN/PA documentation must also include either the abnormal value or reference the abnormal value.
    ▪ Normal for that patient
    ▪ Is due to a chronic condition
    ▪ Is due to a medication

• If there is physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time indicating hypotension or low blood pressure (SBP <90 mmHg or MAP <65 mmHg) is due to the following, the criteria value should be used.
  o Acute condition
  o Acute injury on a chronic condition

  **Example:**
  Hypotension due to acute exacerbation on chronic heart failure.

• If there is physician/APN/PA documentation prior to or within 24 hours of Severe Sepsis Presentation Time indicating the acute condition is due to a non-infectious source/process, it should not be used (Refer to Severe Sepsis Present to determine if a condition is an infection).

  **Example:**
  Hypotension due to acute blood loss secondary to trauma.

• If there is physician/APN/PA or nursing documentation that a low blood pressure 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 or discharge summary.

• If criteria for Septic Shock are not met, but there is physician/APN/PA documentation of Septic Shock, choose Value “1.”

• 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:
  o The documentation or value and recorded date and time is present and is the earliest date and time recorded for the criteria.

• If there is documentation of clinical criteria being met or there is physician/APN/PA documentation of Septic Shock and within 6 hours after this documentation there is additional physician/APN/PA documentation indicating the patient is not septic, does not have Sepsis, Severe Sepsis, Septic Shock, or Septic Shock is due to a viral, fungal or parasitic infection choose Value “2.”

• 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.
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<td>Probable</td>
<td>Ruled out</td>
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<tr>
<td>Differential Diagnosis</td>
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</tr>
<tr>
<td>Suspicious for</td>
<td>Questionable</td>
</tr>
<tr>
<td>Concern for</td>
<td></td>
</tr>
</tbody>
</table>

**Impacts:**

*Septic Shock Present*

**Rationale:** The *Septic Shock Present* data element inclusion and exclusion guidelines for abstraction for infections and Severe Sepsis are being updated to provide additional guidance.

**Description of Changes:**

**Inclusion Guidelines for Abstraction**

**Change to:**

- Septic Shock
- Severe Sepsis with Shock

**Exclusion Guidelines for Abstraction**

**Change to:**

- Bacteremia
- Septicemia
- Shock (not referenced as related to Severe Sepsis or Septic Shock)

**Impacts:**

*Septic Shock Presentation Date*

**Rationale:** The *Septic Shock Presentation Date* data element is being updated to provide additional guidance.

**Description of Changes:**

**Definition**

**Change to:**

The earliest date on which the final criterion was met to establish the presence of septic shock.

**Suggested Data Collection Question**

**Change to:**

What was the date on which the last criterion was met to establish the presence of septic shock?

**Notes for Abstraction**

**Change to:**

- Use the earliest date on which the final criterion for septic shock was noted (see *Septic Shock Present* data element for criteria list) or the earliest date the physician/APN/PA documented septic shock.
- Septic Shock identified by severe sepsis present and persistent hypotension (*Septic Shock Present* criteria a):
  - Use the later date of either severe sepsis presentation or persistent hypotension.
For persistent hypotension, use the date of the last consecutive blood pressure reading that identifies the presence of persistent hypotension.

- Septic Shock identified by severe sepsis present and initial lactate $\geq 4$ (Septic Shock Present criteria b):
  - Use the later date of either severe sepsis presentation or the initial lactate level result.

- For patients with multiple septic shock presentation dates, only abstract the earliest presentation date.
- If septic shock is present on arrival to the Emergency Department or if the physician/APN/PA note states septic shock was present on arrival, use the earliest documented arrival date.
- If the physician/APN/PA note states septic shock was present on admission, use the earliest documented hospital observation/inpatient admission date.
- If septic shock is in a physician/APN/PA note without a specific date documented within the note or documented using the acronym POA, use the date the note was started or opened.

**Impacts:**

**Septic Shock Presentation Time**

**Rationale:** The Septic Shock Presentation Time data element is being updated to provide additional guidance.

**Description of Changes:**

**Definition**

**Change** to:

The earliest time at which the final criterion was met to establish the presence of septic shock.

**Notes for Abstraction**

**Change** to:

- Use the earliest time at which the final criterion for septic shock was noted (see Septic Shock Present data element for criteria list) or the earliest time the physician/APN/PA documented septic shock.
- Septic Shock identified by severe sepsis present and persistent hypotension (Septic Shock Present criteria a):
  - Use the later time of either severe sepsis presentation or persistent hypotension.
  - For persistent hypotension, use the time of the last consecutive blood pressure reading that identifies the presence of persistent hypotension.
- Septic Shock identified by severe sepsis present and initial lactate $\geq 4$ (Septic Shock Present criteria b):
  - Use the later time of either severe sepsis presentation or the initial lactate level result.
- For patients with multiple septic shock presentation times, only abstract the earliest presentation time.
- If septic shock is present on arrival to the Emergency Department or if the physician/APN/PA note states septic shock was present on arrival, use the earliest documented arrival time.
- If the physician/APN/PA note states septic shock was present on admission, use the earliest documented hospital observation/inpatient admission time.
If septic shock is in a physician/APN/PA note without a specific time documented within the note or documented using the acronym POA, use the time the note was started or opened.

Impacts:  
Severe Sepsis Present

Rationale: The Severe Sepsis Present data element is being updated to provide additional guidance.

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 indicates a dose was given within 6 hours of criteria b and c, pharmacy note that patient is on vancomycin for pneumonia).  
     • 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 hospital observation/inpatient admission date and time.  
     • 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.
  i. 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.
  ii. 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.
  iii. 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.
    o If there is physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time indicating hypotension or low blood pressure (SBP <90 mmHg or MAP <65 mmHg) is due to the following, the criteria value should be used.
      ▪ Acute condition
      ▪ Acute injury on chronic condition
        **Example:**
        Hypotension due to acute exacerbation on chronic heart failure.
    o If there is physician/APN/PA documentation prior to or within 24 hours of Severe Sepsis Presentation Time indicating the acute condition is due to a non-infectious source/process, it should not be used (Refer to Severe Sepsis Present to determine if a condition is an infection)
Examples:
- Hypotension due to acute blood loss secondary to trauma, do not use hypotension.
- Hypotension due to acute exacerbation of chronic heart failure due to worsening heart failure, do not use hypotension.

- 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 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 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)
• If there is physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time that SIRS criteria or a sign of organ dysfunction is due to the following, it should not be used. Inferences should not be made.
  o It is required the same physician/APN/PA documentation must also include either the abnormal value or reference the abnormal value.
    ▪ Normal for that patient
    ▪ Is due to a chronic condition
    ▪ Is due to a medication
• Documentation of a term defining an abnormal value of a SIRS criterion or sign of organ dysfunction that is documented as normal for the patient, due to a chronic condition, or due to a medication is sufficient to disregard the SIRS criterion or sign of organ dysfunction.
  Examples:
  o Thrombocytopenia due to chemo, do not use the abnormal platelet value.
  o A-fib with tachycardia or RVR, do not use the elevated heart rate.
• If there is physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time indicating a SIRS criterion or sign of organ dysfunction is due to the following, the criteria value should be used:
  o Acute condition
  o Acute on chronic condition
  Example:
  Elevated lactate secondary to seizure.
• If there is physician/APN/PA documentation prior to or within 24 hours of Severe Sepsis Presentation Time indicating the acute condition is due to a non-infectious source/process, it should not be used (Refer to Severe Sepsis Present criteria “a” to determine if a condition is an infection).
  Example:
  Elevated lactate secondary to seizure post brain injury, do not use lactate level.
• If there is physician/APN/PA documentation prior to or within 24 hours of Severe Sepsis Presentation Time indicating SIRS criteria or a sign of organ dysfunction is due to or possibly due to an infection, Severe Sepsis or Septic Shock, the value should be used.
• Vital signs documented in the operating room (OR) should not be used.
• SIRS criteria or a sign of organ dysfunction due to artificial interventions (e.g., respiratory rate is 24, vent rate set at 24) should not be used.
• 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 an infection, Sepsis, Severe Sepsis, or Septic Shock with 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 there is physician/APN/PA or nursing documentation that SIRS criteria or sign of organ dysfunction is invalid, erroneous or questionable, disregard that value.
• Use the time vital signs were taken or obtained. If time taken or obtained is not available, use recorded or documented time.
• Use the earliest time laboratory values are reported/resulted, not the collection 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 documentation of an infection, Severe Sepsis, or Septic Shock in a discharge note or discharge summary.

• If there is documentation of clinical criteria being met or physician/APN/PA documentation of Severe Sepsis and within 6 hours after there is additional physician/APN/PA documentation indicating the patient is not septic, does not have Sepsis, Severe Sepsis, or Severe Sepsis is due to a viral, fungal, or parasitic infection, choose Value “2.”

• For documentation of an infection or Severe Sepsis 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.

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</table>

**Impacts:**

**Severe Sepsis Present**

**Rationale:** The Inclusion and Exclusion Guidelines for Abstraction are being updated to provide additional guidance.

**Description of Changes:**

Inclusion and Exclusion Guidelines for Abstraction

**Change** format and content for ‘Severe Sepsis’ and ‘Infections’ to:

**Guidelines for Abstraction: Severe Sepsis**

**Inclusions**

Documentation that is acceptable for Severe Sepsis:

• PHYSICIAN/APN/PA DOCUMENTATION ONLY
• Severe Sepsis
**Exclusions**

Documentation that is not acceptable for Severe Sepsis:

- Bacteremia
- Septicemia

**Guidelines for Abstraction: Infections**

**Inclusions**

Documentation that is acceptable for an infection. The following is a list of conditions commonly associated with Severe Sepsis that are considered infections.

*(This is not an all-inclusive list)*

- Abscess
- Acute abdomen
- Acute abdominal infection
- Blood stream catheter infection
- Bone/joint infection
- Chronic Obstructive Pulmonary Disease (COPD) acute exacerbation
- Endocarditis
- Gangrene
- Implantable device infection
- Infection
- Infectious
- Meningitis
- Necrosis
- Necrotic/ischemic/infarcted bowel
- Pelvic Inflammatory Disease
- Perforated bowel
- Pneumonia, empyema
- Purulence/pus
- Sepsis
- Skin/soft tissue infection
- Suspect infection, source unknown
- Urosepsis, Urinary tract infection
- Wound infection

**Exclusions**

Documentation that is not acceptable for an infection:

- Colonization, positive screens, or positive cultures (e.g., MRSA, VRE, or for other bacteria) without physician/APN/PA documentation referencing an infection.
- Fungal infections
- History of infection, recent infection, or recurrent infection that is not documented as a current or active infection.
- Orders for tests or screens without documentation of a suspected infection.
- Parasitic infections
• Results of tests without documentation of a suspected infection (e.g., infiltrates on chest x-ray, positive cultures).
• Signs or symptoms of an infection without supportive documentation.
• Viral infections

**Impacts:**

*Severe Sepsis Presentation Date*

**Rationale:** The *Severe Sepsis Presentation Date* data element is being updated to provide additional guidance.

**Description of Changes:**

**Definition**

**Change to:**
The earliest date on which the final criterion was met to establish the presence of severe sepsis.

**Notes for Abstraction**

**Change to:**
- Use the earliest date the final clinical criterion for severe sepsis was noted (see *Severe Sepsis Present* data element for clinical criteria list) or the earliest date the physician/APN/PA documented severe sepsis.
- For patients with multiple severe sepsis presentation dates, only abstract the earliest presentation date.
- If severe sepsis or septic shock is documented in a physician/APN/PA note or documented using the acronym POA without a specific date, use the date the note was started or opened.
- For patients who enter the Emergency Department with severe sepsis or if the physician/APN/PA note states severe sepsis was present on arrival, use the earliest documented arrival date.
- If the physician/APN/PA note states severe sepsis was present on admission, use the earliest documented hospital observation/inpatient admission date.
- If clinical criteria for severe sepsis are met after physician/APN/PA documentation of septic shock, enter the date the physician/APN/PA documented septic shock.
- 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, enter the earliest date septic shock was documented for this data element.

**Impacts:**

*Severe Sepsis Presentation Time*

**Rationale:** The *Severe Sepsis Presentation Time* data element is being updated to provide additional guidance.

**Description of Changes:**

**Definition**

**Change to:**
The earliest time at which the final criterion was met to establish the presence of severe sepsis.
Notes for Abstraction

Change to:

- Use the earliest time the final clinical criterion for severe sepsis was noted (see Severe Sepsis Present data element for clinical criteria list) or the earliest time the physician/APN/PA documented severe sepsis.
- For patients with multiple severe sepsis presentation times, only abstract the earliest presentation time.
- If severe sepsis or septic shock is documented in a physician/APN/PA note without a specific time or documented using the acronym POA, use the time the note was started or opened.
- For patients who enter the Emergency Department with severe sepsis or if the physician/APN/PA note states severe sepsis was present on arrival, use the earliest documented arrival time.
- If the physician/APN/PA note states severe sepsis was present on admission, use the earliest documented hospital observation/inpatient admission time.
- If clinical criteria for severe sepsis are met after physician/APN/PA documentation of septic shock, enter the time the physician/APN/PA documented septic shock.
- 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, enter the earliest time septic shock was documented.

Impacts:
Skin Examination Date

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question

Change to:
On what date was a skin examination documented by a physician/APN/PA?

Impacts:
Skin Examination Date

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

Description of Changes:
Notes for Abstraction

Change first bullet point to:
- Physician/APN/PA documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.

Change third bullet point to:
- If there are multiple skin examinations performed, abstract the date of the latest measurement documented within the allowable time window.
Impacts:
*Skin Examination Performed*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**
**Suggested Data Collection Question**
**Change to:**
Was a skin examination documented by a physician/APN/PA?

Impacts:
*Skin Examination Performed*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to determine if the assessment was performed.

**Description of Changes:**
**Notes for Abstraction**
**Change to:**
- Physician/APN/PA documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date*, *Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.
- Skin Examination can be documented by **any one of the following 3 ways:**
  - Physician/APN/PA documentation of skin color or appearance or condition.
    - This can be documented as any one of the three (color, appearance, or condition).
    - Documentation of an inclusion term or similar terminology is acceptable.
      **Example:**
      Physician/APN/PA documents in the skin section “pink, warm and dry.”
    - Documentation of an inclusion term that is not identified as or references the skin, is acceptable.
  - Physician/APN/PA documentation that a skin exam was reviewed, performed, or attested to reviewing or performing.
    - If documented this way, reference to skin color, appearance, or condition is not required.
      **Example:**
      Physician/APN/PA documents “Reviewed the nurse’s skin assessment.”
  - Physician/APN/PA documentation of performing or attesting to performing a physical exam, perfusion (re-perfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam.
      **Example:**
      Physician/APN/PA documents “sepsis exam done.”
      - A title or heading of a form, section, or assessment should not be used.
        **Example:**
        In the H&P there is a heading called “physical exam.”
- If there are no skin examinations documented or documentation reflects the assessment was not performed in the allowable time window, choose Value “2.”
If the skin examination is in a physician/APN/PA note without a specific time, use the time the note was started or opened.

**Impacts:**
*Skin Examination Time*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**
*Suggested Data Collection Question*

**Change** to:
At what time was a skin examination documented by a physician/APN/PA?

**Impacts:**
*Skin Examination Time*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

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

**Change** first bullet point to:
- Physician/APN/PA documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date*, *Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.

**Change** third bullet point to:
- If there are multiple skin examinations performed, abstract the time of the latest measurement documented within the allowable time window.

**Impacts:**
*Tobacco Use Status*

**Rationale:** The data element is being updated to provide clarification of the screening timeframe and guidance on screening of the intubated patient.

**Description of Changes:**
*Definition*

**Change** first sentence to: Documentation within the first day of admission (by the end of Day 1) of the adult patient’s tobacco use status within the past 30 days prior to the day of hospital admission.

**Allowable Values**

**Change** last three values from:
- 4 The patient refused the tobacco use screen.
- 5 The patient was not screened for tobacco use during this hospitalization or unable to determine the patient’s tobacco use status from medical record documentation.
- 6 The patient was not screened for tobacco use during the first day of admission because of cognitive impairment.
To:
4 The patient refused the tobacco use screen within the first day of admission (by the end of Day 1).
5 The patient was not screened for tobacco use within the first day of admission (by the end of Day 1) or unable to determine the patient’s tobacco use status from medical record documentation.
6 The patient was not screened for tobacco use within the first day of admission (by the end of Day 1) because of cognitive impairment.

Notes for Abstraction

Change first bullet point to:
- The tobacco use status screening must have occurred within the first day of admission (by the end of Day 1). This includes the day of admission which is defined as Day 0, and the day after admission which is defined as Day 1.

  EXCEPTION:
  If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the current medical record.

Remove bullet point 14:
- The tobacco use status screening timeframe must have occurred within the first day of admission. This includes the day of admission which is defined as day zero, and the day after admission which is defined as the first day.

  EXCEPTION:
  If the screening was performed prior to admission to the psychiatric unit, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the psychiatric unit medical record.

Change bullet points 15, 16, 18, and 19 to:
- Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for tobacco use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first day of admission (by the end of Day 1).
- If there is documentation within the first day of admission (by the end of Day 1) that the patient was psychotic with documented symptoms, e.g., hallucinating, non-communicative, catatonic, etc., which prevented them from answering questions reliably, they would be considered cognitively impaired.
- 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.
- If there is documentation of any of the examples of cognitive impairment below within the first day of admission (by the end of Day 1), select Value “6” regardless of conflicting documentation.
Impacts:
Vital Signs Review Date

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
On what date was a vital signs review documented by a physician/APN/PA?

Impacts:
Vital Signs Review Date

Rationale: The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

Description of Changes:
Notes for Abstraction
Change first bullet point to:
• Physician/APN/PA documentation must occur or reflect the assessment was performed between Crystalloid Fluid Administration Date, Crystalloid Fluid Administration Time and six hours after Septic Shock Presentation Date, Septic Shock Presentation Time.

Change third bullet point to:
• If there are multiple vital sign reviews performed, abstract the date of the latest measurement documented within the allowable time window.

Remove forth bullet point:
• Do not use multiple vital signs reviews done at different times and dates to satisfy the requirement of all four components. For example, do not use a temperature recorded in one entry and pulse, respirations, and blood pressure from another recorded entry.

Impacts:
Vital Signs Review Performed

Rationale: The Suggested Data Collection Question was simplified to decrease abstraction burden.

Description of Changes:
Suggested Data Collection Question
Change to:
Was a vital signs review documented by a physician/APN/PA?
• Physician/APN/PA documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date*, *Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*.

• Vital signs review can be documented by **any one of the following 3 ways:**
  o Physician/APN/PA documentation of temperature, pulse (also referred to as heart rate), respirations, and blood pressure.
    ▪ All four elements (Temperature, pulse or heart rate, respirations, blood pressure) must be referenced in a single note.
  o Physician/APN/PA documentation that vital signs were reviewed, performed, or attested to reviewing or performing.
    ▪ Listing each vital sign element (Temperature, pulse or heart rate, respirations, blood pressure) is not required.
      **Example:**
      Physician/APN/PA documents “Reviewed nurse’s documentation of vital signs.”
  o Physician/APN/PA documentation of performing or attesting to performing a physical exam, perfusion (re-perfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam.
      **Example:**
      Physician/APN/PA documents “sepsis exam done.”
    ▪ A title or heading of a form, section, or assessment should not be used.
      **Example:**
      In the H&P there is a heading called “physical exam.”

• If there are no vital signs reviews documented or documentation reflects the assessment was not performed in the allowable time window, choose Value “2.”

• If the vital signs review is in a physician/APN/PA note without a specific time, use the time the note was started or opened.

**Impacts:**

*Vital Signs Review Time*

**Rationale:** The Suggested Data Collection Question was simplified to decrease abstraction burden.

**Description of Changes:**

*Suggested Data Collection Question*

*Change* to:

At what time was a vital signs review documented by a physician/APN/PA?

**Impacts:**

*Vital Signs Review Time*

**Rationale:** The Notes for Abstraction were updated to provide guidance on the timeframe and how to address if there are multiple assessments performed.

**Description of Changes:**

*Notes for Abstraction*

*Change* first bullet point to:

- Physician/APN/PA documentation must occur or reflect the assessment was performed between *Crystalloid Fluid Administration Date*, *Crystalloid Fluid Administration Time* and six hours after *Septic Shock Presentation Date*, *Septic Shock Presentation Time*. 
Change third bullet point to:
- If there are multiple vital sign reviews performed, abstract the time of the latest measurement documented within the allowable time window.

Remove fourth bullet point:
- Do not use multiple vital signs reviews done at different times and dates to satisfy the requirement of all four components. For example, do not use a temperature recorded in one entry and pulse, respirations, and blood pressure from another recorded entry.

### SECTION 2 – Measurement Information

#### Subsection 2.1 – Severe Sepsis and Septic Shock (SEP)

**Impacts:**
SEP Data Element List

**Rationale:** The data element *Patient HIC#* is being deleted as it is not used by CMS in the abstraction process and may contain the patient’s Social Security Number.

**Description of Changes:**
General Data Elements Table
Remove row in its entirety:
*Patient HIC#*

**Impacts:**
SEP Data Element List

**Rationale:** The measure is being revised to exclude patients that are enrolled in a clinical trial related to sepsis care and management.

**Description of Changes:**
SEP Data Elements Table
Add row under ‘Name’ column and ‘Collected For’ column, respectively:
Clinical Trial
SEP-1

**Impacts:**
SEP-1

**Rationale:** The algorithm is being updated to allow for exclusion of cases that do not meet the initial lactate collection portion of measure, but are eligible for exclusion based on antibiotic timing.

**Description of Changes:**
Algorithm
Change:
Sequence of the Initial Lactate Collection section of algorithm on page SEP-1-11 with that of the Broad Spectrum or Other Antibiotic Administration section and Blood Culture Collection section of the algorithm on pages SEP-1-12, and SEP-1-13 so that the Initial Lactate Collection section is after the Blood Culture Collection section.
Impacts:
SEP-1

Rationale: The measure is being revised to exclude patients that are enrolled in a clinical trial related to sepsis care and management.

Description of Changes:
Algorithm
Add:
Clinical Trial data element decision box to algorithm after Transfer from Another Hospital or ASC decision box.
If “Missing” branch to left goes to outcome category “X”
If “Yes” branch to right goes to outcome category “B”
If “No” branch down goes to off page connector “G”

Impacts:
SEP-1

Rationale: The measure is being revised to exclude patients that are enrolled in a clinical trial related to sepsis care and management.

Description of Changes:
Denominator Statement - Excluded Populations
Add new bullet point:
• Patients enrolled in a clinical trial for sepsis, severe sepsis or septic shock treatment or intervention

Denominator Statement - and Data Elements
Add new bullet point:
• Clinical Trial

Impacts:
SEP-1

Rationale: This change is to clarify the timing relationship of Initial Hypotension and Crystalloid Fluid Administration in the Numerator Statement.

Description of Changes:
Numerator Statement
Remove:
AND ONLY if Septic Shock present:
Received within three hours of presentation of septic shock:
• Resuscitation with 30 ml/kg crystalloid fluids
Replace with:
AND ONLY if:
Initial Hypotension present initiated within three hours of Initial Hypotension:
• Resuscitation with 30 mL/kg crystalloid fluids
OR
Septic Shock Present initiated within three hours of septic shock presentation:
• Resuscitation with 30 mL/kg crystalloid fluids
Impacts:
SEP-1

Rationale: This change is to clarify that the allowable options in the numerator have expanded in the data elements.

Description of Changes:
Numerator Statement
Change last bullet point to:
• Repeat volume status and tissue perfusion assessment

Impacts:
SEP-1

Rationale: The denominator exclusion is being updated to expand the timeframe for documentation of comfort measures only or palliative care when severe sepsis is present.

Description of Changes:
Denominator Statement – Excluded Populations
Change “3” in first bullet point to “6”

Subsection 2.2 – Venous Thromboembolism (VTE)

Impacts:
VTE Data Element List

Rationale: The data element Patient HIC# is being deleted as it is not used by CMS in the abstraction process and may contain the patient’s Social Security Number.

Description of Changes:
General Data Elements Table
Remove row in its entirety:
Patient HIC#

Impacts:
VTE-6

Rationale: This change removes a redundant logic point from VTE-6 because cases with a Principal Diagnosis Code on Tables 7.03 or 7.04 have already been rejected from the initial patient population.

Description of Changes:
Algorithm
Remove:
ICD-10-CM-Principal Diagnosis Code decision box and associated branches

Subsection 2.4 – Global Initial Patient Population (ED, IMM, TOB, SUB) (no updates)
### Subsection 2.5 – Emergency Department (ED)

**Impacts:**
ED Data Element List

**Rationale:** The data element *Patient HIC#* is being deleted as it is not used by CMS in the abstraction process and may contain the patient’s Social Security Number.

**Description of Changes:**
General Data Elements Table
Remove row in its entirety: *Patient HIC#*

### Subsection 2.6 - Prevention

#### 2.6.1 - Immunization (IMM)

**Impacts:**
Immunization Data Element List

**Rationale:** The data element *Patient HIC#* is being deleted as it is not used by CMS in the abstraction process and may contain the patient’s Social Security Number.

**Description of Changes:**
General Data Elements Table
Remove row in its entirety: *Patient HIC#*

#### 2.6.2 - Substance Use (SUB)

**Impacts:**
SUB

**Rationale:** Effective January 1, 2018, the SUB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

**Description of Changes:**
SUB List
Remove under SUB Measure Set Table:
SUB-4 Alcohol and Drug Use: Assessing Status after Discharge

SUB Data Elements Table
Remove the following rows in their entirety:
Alcohol or Drug Use Status Post Discharge – Counseling
Alcohol or Drug Use Status Post Discharge - Medication
Alcohol Use Status Post Discharge – Quit Status
Drug Use Status Post Discharge – Quit Status
Follow-up Contact
Follow-up Contact Date

Remove SUB-4 under ‘Collected For’ for the following data elements:
Alcohol Use Status
Comfort Measures Only
Discharge Disposition
Impacts:
SUB-1

Rationale: The Measure Information Form (MIF) is being updated to reflect consistency with guidance for screening time frame.

Description of Changes:

Change to:
Hospitalized patients who are screened within the first day of admission (by end of Day 1) using a validated screening questionnaire for unhealthy alcohol use.

Numerator Statement
Change to:
The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first day of admission (by end of Day 1).

Impacts:
SUB-1

Rationale: The Measure Information Form (MIF) algorithm is being updated to reflect consistency with guidance for screening time frame.

Description of Changes:
Algorithm - Numerator
Change to:
The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first day of admission (by end of Day 1).

Impacts:
SUB-4

Rationale: Effective January 1, 2018, the SUB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

Description of Changes:
Remove the SUB-4 Measure Information Form in its entirety

2.6.3 - Tobacco Treatment (TOB)

Impacts:
TOB

Rationale: Effective January 1, 2018, the TOB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

Description of Changes:
Remove under TOB Measure Set Table:
TOB-4 Tobacco Use: Assessing Status after Discharge
TOB Data Elements Table

**Remove** the following rows in their entirety:
- Follow-up Contact
- Follow-up Contact Date
- Tobacco Use Status Post Discharge - Counseling
- Tobacco Use Status Post Discharge - Medication
- Tobacco Use Status Post Discharge – Quit Status

**Remove** TOB-4 under ‘Collected For’ for the following data elements:
- Comfort Measures Only
- Discharge Disposition
- Prescription for Tobacco Cessation Medication
- Referral for Outpatient Tobacco Cessation Counseling
- Tobacco Use Status

**Impacts:**

**TOB-1**

**Rationale:** The Measure Information Form (MIF) is being updated to reflect consistency with guidance for screening time frame.

**Description of Changes:**

**Description**

**Change** to:

Hospitalized patients who are screened within the first day of admission (by end of Day 1) for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days.

**Numerator Statement**

**Change** to:

The number of patients who were screened for tobacco use status within the first day of admission (by end of Day 1).

**Impacts:**

**TOB-1**

**Rationale:** The rationale and selected references for the TOB-1, 2, and 3 measures are being updated to include current statistics and resources.

**Description of Changes:**

**TOB-1 MIF**

**Change** Rationale to:

Tobacco use is the single greatest cause of disease in the United States today and accounts for more than 480,000 deaths each year (CDC MMWR 2014). Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases (DHHS 2014). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated to be at least $130 billion per year in direct medical expenses for adults, and over $150 billion in lost productivity (DHHS 2014).

There is strong and consistent evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the user’s risk of suffering from tobacco-
related disease and improve outcomes for those already suffering from a tobacco-related
disease (DHHS 2000; Baumeister 2007; Lightwood 2003 and 1997; Rigotti 2012). Effective,
evidence-based tobacco dependence interventions have been clearly identified and include
brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved
medications. These treatments are clinically effective and extremely cost-effective relative to
other commonly used disease prevention interventions and medical treatments. Hospitalization
(both because hospitals are a tobacco-free environment and because patients may be more
motivated to quit as a result of their illness) offers an ideal opportunity to provide cessation
assistance that may promote the patient's medical recovery. Patients who receive even brief
advice and intervention from their care providers are more likely to quit than those who receive
no intervention (DHHS, 2008).

Change Selected References to:


Impacts:
TOB-1

Rationale: The Measure Information Form (MIF) algorithm is being updated to reflect consistency with guidance for screening time frame.

Description of Changes:
Algorithm - Numerator
Change to:
The number of patients who were screened for tobacco use status within the first day of admission (by end of Day 1).

Impacts:
TOB-2

Rationale: The rationale and selected references for the TOB-1, 2, and 3 measures are being updated to include current statistics and resources.

Description of Changes:
TOB-2 MIF
Change Rationale to:
Tobacco use is the single greatest cause of disease in the United States today and accounts for more than 480,000 deaths each year (CDC MMWR 2014). Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases (DHHS 2014). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated to be at least $130 billion per year in direct medical expenses for adults, and over $150 billion in lost productivity (DHHS 2014).

There is strong and consistent evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the user's risk of suffering from tobacco-related disease and improve outcomes for those already suffering from a tobacco-related disease (DHHS 2000; Baumeister 2007; Lightwood 2003 and 1997; Rigotti 2012). Effective, evidence-based tobacco dependence interventions have been clearly identified and include brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved medications. These treatments are clinically effective and extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments. Hospitalization (both because hospitals are a tobacco-free environment and because patients may be more motivated to quit as a result of their illness) offers an ideal opportunity to provide cessation assistance that may promote the patient's medical recovery. Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention (DHHS, 2008).

Change Selected References to:


Impacts: TOB-3

Rationale: The rationale and selected references for the TOB-1, 2, and 3 measures are being updated to include current statistics and resources.

Description of Changes: TOB-3 MIF

Change Rationale to:

Tobacco use is the single greatest cause of disease in the United States today and accounts for more than 480,000 deaths each year (CDC MMWR 2014). Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases (DHHS 2014). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated to be at least $130 billion per year in direct medical expenses for adults, and over $150 billion in lost productivity (DHHS 2014).

There is strong and consistent evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the user's risk of suffering from tobacco-related disease and improve outcomes for those already suffering from a tobacco-related disease (DHHS 2000; Baumeister 2007; Lightwood 2003 and 1997; Rigotti 2012). Effective, evidence-based tobacco dependence interventions have been clearly identified and include brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved
medications. These treatments are clinically effective and extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments. Hospitalization (both because hospitals are a tobacco-free environment and because patients may be more motivated to quit as a result of their illness) offers an ideal opportunity to provide cessation assistance that may promote the patient's medical recovery. Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention (DHHS, 2008).

**Change** Selected References to:


**Impacts:**

TOB-4

**Rationale:** Effective January 1, 2018, the TOB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

**Description of Changes:**

Measure Information Form

Remove the TOB-4 Measure Information Form in its entirety
SECTION 3 – Missing and Invalid Data *(no updates)*

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

SECTION 9 – Data Transmission

**Transmission Overview**

**Impacts:**
Joint Commission Data Transmission

**Rationale:** The data element *Patient HIC#* is being deleted as it is not used by CMS in the abstraction process and may contain the patient’s Social Security Number.

**Description of Changes:**
Hospital Clinical Data
Remove under fifth bullet:
- Patient HIC #

**Impacts:**
CMS and Joint Commission Guidelines for Submission of Data

**Rationale:** The data element *Patient HIC#* is being deleted as it is not used by CMS in the abstraction process and may contain the patient’s Social Security Number.

**Description of Changes:**
Data Elements Not Accepted by The Joint Commission
Remove:
- *Patient HIC#*

Required Patient Identifiers Based on Payment Source
Remove:
2. *Patient HIC# (PTHIC)* is required for all patients with a standard HIC#. (Refer to Definition of Valid Patient HIC below.)

Definition of Valid Patient HIC (PTHIC)
Remove section in its entirety.

Unique Record Key
Remove under ‘Episode of Care’ and re-number list:
3. *Patient HIC#*

**Impacts:**
Data Processing Flow: Clinical

**Rationale:** The data element *Patient HIC#* is being deleted as it is not used by CMS in the abstraction process and may contain the patient’s Social Security Number.

**Description of Changes:**
Transmission Data Processing Flow
Change in number 2:
Patient HIC# to Patient Identifier
Transmission Alphabetical Data Dictionary *(no updates)*

Hospital Clinical Data XML File Layout

**Impacts:**
Elements - `<pthic>`

**Rationale:** The data element *Patient HIC#* is being removed from the Specifications Manual as it may contain the patient’s social security number and is no longer needed for purposes of abstraction.

**Description of Changes:**
**Remove** row: `<pthic>`

**Impacts:**
Detail Elements Info

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

**Description of Changes:**
**Remove** the following data element rows:
- Alcohol or Drug Use Status Post Discharge – Counseling
- Alcohol or Drug Use Status Post Discharge – Medication
- Alcohol Use Status Post Discharge – Quit Status
- Drug Use Status Post Discharge – Quit Status
- Follow Up Contact
- Follow Up Contact Date
- Tobacco Use Status Post Discharge – Counseling
- Tobacco Use Status Post Discharge – Medication
- Tobacco Use Status Post Discharge – Quit Status

**Impacts:**
Detail Elements Info

**Rationale:** The SUB-4 and TOB-4 measures are being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

**Description of Changes:**
**Add** the following data elements under Retired or Deleted Data Elements Effective 01/01/2018 Discharges:
- Alcohol or Drug Use Status Post Discharge – Counseling
- Alcohol or Drug Use Status Post Discharge – Medication
- Alcohol Use Status Post Discharge – Quit Status
- Drug Use Status Post Discharge – Quit Status
- Follow Up Contact
- Follow Up Contact Date
- Tobacco Use Status Post Discharge – Counseling
- Tobacco Use Status Post Discharge – Medication
- Tobacco Use Status Post Discharge – Quit Status
Impacts:
Detail Elements Info - Alcohol Use Status

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

Description of Changes:
Change Allowable Values to:
1 The patient is screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.
2 The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefitting from brief intervention.
3 The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.
4 The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefitting from brief intervention.
5 The patient refused the screen for alcohol use within the first day of admission (by end of Day 1).
6 The patient was not screened for alcohol use within the first day admission (by end of Day 1) or unable to determine from medical record documentation.
7 The patient was not screened for alcohol use within the first day of admission (by end of Day 1) because of cognitive impairment.

Impacts:
Detail Elements Info - Bedside Cardiovascular Ultrasound Date

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

Description of Changes:
Change Suggested Data Collection Question to:
On what date was a bedside cardiovascular ultrasound performed?

Impacts:
Detail Elements Info - Bedside Cardiovascular Ultrasound Performed

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

Description of Changes:
Change Suggested Data Collection Question to:
Was a bedside cardiovascular ultrasound performed?

Impacts:
Detail Elements Info - Bedside Cardiovascular Ultrasound Time

Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.
Description of Changes:
Change Suggested Data Collection Question to:
At what time was a bedside cardiovascular ultrasound performed?

Impacts:
Detail Elements Info - Broad Spectrum or Other Antibiotic Administration

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

Description of Changes:
Change Suggested Data Collection Question to:
Was a broad spectrum or other antibiotic administered in the time window 24 hours prior to or 3 hours after Severe Sepsis Presentation Date and Time?

Impacts:
Detail Elements Info - Broad Spectrum or Other Antibiotic Administration Date

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

Description of Changes:
Change Suggested Data Collection Question to:
What was the earliest date on which an antibiotic was started in the time window of 24 hours preceding or 3 hours after Severe Sepsis Presentation Date and Time?

Impacts:
Detail Elements Info - Broad Spectrum or Other Antibiotic Administration Selection

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

Description of Changes:
Change Suggested Data Collection Question to:
Was the antibiotic administered within 3 hours after the Severe Sepsis Presentation Date and Time consistent with antibiotic selection guidelines in the Notes for Abstraction?

Impacts:
Detail Elements Info - Broad Spectrum or Other Antibiotic Administration Time

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

Description of Changes:
Change Suggested Data Collection Question to:
What was the earliest time at which an antibiotic was started in the time window of 24 hours preceding or 3 hours after Severe Sepsis Presentation Data and Time?

Impacts:
Detail Elements Info - Capillary Refill Examination Date

Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.
Description of Changes:
Change Suggested Data Collection Question to:
On what date was a capillary refill examination documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Capillary Refill Examination Performed
Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Suggested Data Collection Question to:
Was a capillary refill examination documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Capillary Refill Examination Time
Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Suggested Data Collection Question to:
At what time was a capillary refill examination documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Cardiopulmonary Evaluation Date
Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Suggested Data Collection Question to:
On what date was a cardiopulmonary evaluation documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Cardiopulmonary Evaluation Performed
Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Suggested Data Collection Question to:
Was a cardiopulmonary evaluation documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Cardiopulmonary Evaluation Time
Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Suggested Data Collection Question to:
At what time was a cardiopulmonary evaluation documented by a physician/APN/PA?
Impacts:
Detail Elements Info - Central Venous Oxygen Measurement

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

Description of Changes:
Change Suggested Data Collection Question to:
Was a central venous oxygen measurement obtained?

Impacts:
Detail Elements Info - Central Venous Oxygen Measurement Date

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

Description of Changes:
Change Suggested Data Collection Question to:
What was the date on which the central venous oxygen measurement was obtained?

Impacts:
Detail Elements Info - Central Venous Oxygen Measurement Time

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

Description of Changes:
Change Suggested Data Collection Question to:
What was the time at which a central venous oxygen measurement was obtained?

Impacts:
Detail Elements Info - Central Venous Pressure Measurement

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

Description of Changes:
Change Suggested Data Collection Question to:
Was a central venous pressure measurement obtained?

Impacts:
Detail Elements Info - Central Venous Pressure Measurement Date

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

Description of Changes:
Change Suggested Data Collection Question to:
What was the date on which a central venous pressure measurement was obtained?

Impacts:
Detail Elements Info - Central Venous Pressure Measurement Time

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

**Change** Suggested Data Collection Question to:

What was the time at which a central venous pressure measurement was obtained?

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**Impacts:**

Detail Elements Info - Clinical Trial

**Rationale:** The data element *Clinical Trial* is being added to the SEP-1 measure logic.

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**Description of Changes:**

**Change** Suggested Data Collection Question to:

During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. VTE or SEP-1)?

**Add** to the Applicable Measure(s):

SEP-1

**Add** to the Programming Notes:

Collected by CMS Only: SEP-1

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**Impacts:**

Detail Elements Info - Discharge Disposition

**Rationale:** The SUB-4 and TOB-4 measures are being removed from the Specifications Manual.

**Description of Changes:**

**Remove** SUB-4 and TOB-4 under Applicable Measure(s)

**Remove** from Programming Notes:

Joint Commission Data Collection Suspended: SUB-4, TOB-4

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**Impacts:**

Detail Elements Info - Fluid Challenge Date

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

**Description of Changes:**

**Change** Suggested Data Collection Question to:

On what date was a fluid challenge performed?

---

**Impacts:**

Detail Elements Info - Fluid Challenge Performed

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

**Description of Changes:**

**Change** Suggested Data Collection Question to:

Was a fluid challenge performed?

---

**Impacts:**

Detail Elements Info - Fluid Challenge Time

**Rationale:** Updates are being made to align with the specifications manual alphabetical data dictionary.
Description of Changes:
Change Suggested Data Collection Question to:
At what time was a fluid challenge performed?

Impacts:
Detail Elements Info –
ICD-10-CM Other Diagnosis Codes
ICD-10-CM Principal Diagnosis Code

Rationale: The SUB-4 and TOB-4 measures are being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

Description of Changes:
Remove from the Applicable Measure(s):
SUB-4 and TOB-4

Remove from the Programming Notes:
Suspended by The Joint Commission: TOB-4, SUB-4

Impacts:
Detail Elements Info –
ICD-10-CM Other Procedure Codes
ICD-10-CM Principal Procedure Code

Rationale: The SUB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

Description of Changes:
Remove from Applicable Measure(s):
SUB-4

Remove from Programming Notes:
Suspended by The Joint Commission: SUB-4

Impacts:
Detail Elements Info - Passive Leg Raise Exam Date

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

Description of Changes:
Change Suggested Data Collection Question to:
On what date was a passive leg raise examination documented?

Impacts:
Detail Elements Info - Passive Leg Raise Exam Performed

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

Description of Changes:
Change Suggested Data Collection Question to:
Was there documentation that a passive leg raise examination was performed?
Impacts:
Detail Elements Info - Passive Leg Raise Exam Time

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

Description of Changes:
Change Suggested Data Collection Question to:
At what time was a passive leg raise examination documented?

Impacts:
Detail Elements Info - Peripheral Pulse Evaluation Date

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

Description of Changes:
Change Suggested Data Collection Question to:
On what date was a peripheral pulse evaluation documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Peripheral Pulse Evaluation Performed

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

Description of Changes:
Change Suggested Data Collection Question to:
Was a peripheral pulse evaluation documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Peripheral Pulse Evaluation Time

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

Description of Changes:
Change Suggested Data Collection Question to:
At what time was a peripheral pulse evaluation documented by a physician/APN/PA?

Impacts:
Detail Elements Info – Prescription for Tobacco Cessation Medication
Referral for Outpatient Tobacco Cessation Counseling

Rationale: The SUB-4 measure is being retired and will not be available for selection in meeting Joint Commission ORYX Performance Measure Reporting Requirements.

Description of Changes:
Remove from Applicable Measure(s):
TOB-4

Remove from Programming Notes:
Data Collection Suspended: TOB-4
Impacts:
Detail Elements Info - Referral for Addictions Treatment

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

Description of Changes:
Change Allowable Value 5 to:
The referral for addictions treatment was not offered at any time prior to discharge or unable to determine from medical record documentation.

Impacts:
Detail Elements Info - Septic Shock Presentation Date

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

Description of Changes:
Change Suggested Data Collection Question to:
What was the date on which the last criterion was met to establish the presence of septic shock?

Impacts:
Detail Elements Info - Skin Examination Date

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

Description of Changes:
Change Suggested Data Collection Question to:
On what date was a skin examination documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Skin Examination Performed

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

Description of Changes:
Change Suggested Data Collection Question to:
Was a skin examination documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Skin Examination Time

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

Description of Changes:
Change Suggested Data Collection Question to:
At what time was a skin examination documented by a physician/APN/PA?
Impacts:
Detail Elements Info - Tobacco Use Status

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

Description of Changes:
Change Allowable Values 4, 5, 6 to:
4 The patient refused the tobacco use screen within the first day of admission (by end of Day 1).
5 The patient was not screened for tobacco use within the first day of admission (by end of Day 1) or unable to determine the patient’s tobacco use status from medical record documentation.
6 The patient was not screened for tobacco use within the first day of admission (by end of Day 1) because of cognitive impairment.

Impacts:
Detail Elements Info - Vital Signs Review Date

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

Description of Changes:
Change Suggested Data Collection Question to:
On what date was a vital signs review documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Vital Signs Review Performed

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

Description of Changes:
Change Suggested Data Collection Question to:
Was a vital signs review documented by a physician/APN/PA?

Impacts:
Detail Elements Info - Vital Signs Review Time

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

Description of Changes:
Change Suggested Data Collection Question to:
At what time was a vital signs review documented by a physician/APN/PA?

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)
Impacts: Table Index

Rationale: A table of anticoagulant medications for Sepsis abstraction is being added. If administered to a patient, it will result in disregarding all elevated INR (International Normalized Ratio) or aPTT (Activated Partial Thromboplastin Time) values.

Description of Changes:
Add row under ‘Number’ and ‘Name’ columns respectively:
Table 5.3
Anticoagulants, Sepsis

Impacts: New Table

Rationale: A table of anticoagulant medications for Sepsis abstraction is being added. If administered to a patient, it will result in disregarding all elevated INR (International Normalized Ratio) or aPTT (Activated Partial Thromboplastin Time) values.

Description of Changes:
Add new table:
Table 5.3 Anticoagulants, Sepsis
(refer to manual for new table)