

NYSDOH Sepsis Q&A Session from February 2018 Data Abstraction Meetings

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Adherence variables

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Q: CMS excludes cases if patient on antibiotics > 24 hrs. So, this will be another non alignment?

Q: I think it is very confusing regarding the antibiotics given within 24 hours prior to signs and symptoms of severe or shock. CMS lists this as an exclusion. Is it a total exclusion from following the protocol?

Q: In CMS guidelines it lists being on antibiotics within 24 hours of presentation of severe or shock. Is this applicable to IPRO as well

Q: Is antibiotic selection a pass/fail variable? is it a pass/fail for 3 hour bundle?

Q: So you fail the bundle if antibiotics are given prior to the severe sepsis data time? This is related to antibiotic selection/severe sepsis datetime

Q: If we are aligned with CMS for antibiotic administration, If the patient has received antibiotics > 24 hour prior to SS presentation. Do we need to continue to abstract the record? If so why?

Q: When the antibiotics are administered greater than 24 hours prior to severe sepsis/septic shock, how do we answer the blood culture question? CMS excludes these cases.

Q: Why are we doing fluid reassessment as part of the bundle? What is the scientific reasoning behind it?

Q: Does DOH plan to align with CMS as far as "no exclusion" for fluid resuscitation

Q: Since CMS allows the utilization of IBW to estimate volume of IVF required, is DOH allowing us to use ideal body weight as well? Also, since CMS is allowing the use of antibiotic fluid to be counted towards the 30 cc/kg, is this aligned as well?

Q: There is data showing flood patients with fluid can lead to ARDS and leads to increased mortality? How do you align that data with requiring fluid boluses for all patients?

Q: How about fluid from antibiotics? I do not see that in the data dictionary but CMS is allowing this volume of fluid to be used as of 2018. Thanks!

Q: i.e. Vancomycin is normally in 250ml bags, but the volume is not given for fluid resuscitation.... this should not be abstracted for fluid resuscitation

Q: on the other hand, if antibiotics are added to high volume fluids (1 L bags) and are given for fluid resuscitation, then they should be counted as fluid administration...

Q: My interpretation is if volume is given for the sake of fluid resuscitation, then you can use that volume for fluid administration

Q: Is there a suggested IBW reference, or is the order for their fluid volume assumed to be correct? How do I know what their IBW is?

Q: If we can use IBW, where does that get put so it's not confused? Is it just stated in the note: the physician will use ideal body weight and it is xx kg?

Q: If the IBW is used, does it need to be identified with a number, or is "IBW" sufficient?

Q: So, are you indicating that for NYS, we should be reporting the date time of septic shock even if outside the 6-hour time window?

Q: On the Data Element if a pt. is in Cardiogenic Shock will have a Lactate over 4. We will be able to document this? Am I understanding this correctly?

“If septic shock was determined by severe sepsis with elevated initial lactate of 4 or higher, use the later time of either severe sepsis presentation or when initial lactate result was available. (Not time drawn)”

Q: Please clarify on the difference between the definition of severe sepsis present in DOH and CMS. According to your dictionary, you are in alignment with the definition of CMS.

Q: hi. if the criteria were clinically met for severe sepsis, and if the sign from Organ dysfunction was lactate >4, and if there is no documentation of severe sepsis, will this be a septic shock case or severe sepsis case?

Q: If patient complains of fever but on arrival to ED does not have fever, and has high lactate and one SIRS, which is suspected to be due to infection/sepsis can the fever at home be used in coming up with recognition time?

Q: You had said there is a difference in severe sepsis between CMS and DOH whereas your dictionary states you are in alignment. Please clarify

Q: Given that lactate 4 or > = septic shock, what constitutes severe sepsis? Therefore, would not all DOH inclusions be septic shock patients?

Q: So, if the elevated lactate is r/t another causes than sepsis, is the repeat lactate question excluded?

Q: In CMS's specs organ dysfunction is described in more ways than just by the lactic acid and SBP<90. For example, the INR, platelet count, and total bilirubin. What does CMS say to this if the LA is normal but there are other signs of organ dysfunction as l

Q: They are not all severely ill patients since now you are using a lactate > 2. For instance, a patient that has a lactate of 2.2 is not the same as one that has > 4.

Q: How can you determine the 'time to vasopressors' if you don't collect the date/time that persistent hypotension began?

Q: If 'initial hypotension' = 'no', should we answer 'persistent hypotension' (as it refers to 'persistent or new onset hypotension')?

Comorbidity Variables

Q: Do your auditors taken ventilator time from the flow sheets or from physician note because there are often time differences. Thank you

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Q: For mechanical ventilation: This now includes vented patients as well as Bipap and Cpap (not for sleep apnea), correct??

Q: For mechanical ventilation date/time, is that also for the 6-hour presentation window of for any time during the admission?

Q: If a patient is admitted without respiratory failure but leaves the facility on mechanical ventilation, would that be considered + on the adult comorbidity? (Discovered after severe sepsis or Not present)?

Q: What about viral causes, i.e. flu or RSV? do you advocate giving antibiotics to these patients?

Q: CMS excludes patients with severe sepsis/septic shock related to viral infections such as influenza. Are these patients with only documented influenza as the cause of severe sepsis/septic shock to be included or excluded in data collection and submission?

Q: what are you doing about flu and RSV? These are viral illnesses and many people meet SS/SS criteria, but those patient do not benefit from antibiotic? Your protocols suggest they should get them, when that is not appropriate.

Q: If we are supposed to submit cases of severe sepsis secondary to viral flu, how does this affect the bundle as viral flu patients do not receive antibiotics?

Q: Why aren't CVAs/neurological conditions, trauma patients, and burn patients included in co-morbidities?

Q: is there any thought about adding a short free text field for comorbidities? In particular I would like to note when a patient is admitted with severe burns.

Data Dictionary

Q: Does the 5.1 include all the changes in the 5.0

Q: My apologies, you may have mentioned this but when will version 5.1 be available?

Q: Will the HANYS Sepsis reporting tool be updated to follow the new Data Dictionary? If so, when will this happen?

Q: Can you clarify: Is the new data dictionary version 5.1 going back to January 1, 2018 discharges or is it for July 1st like CMS.

Demographic Variable

Q: Does this mean time zero will be arrival time, not triage time or time of recognition?

Q: Which time zero is this based on?

Q: Has there been any discussion regarding the transfer patients? Abstraction from other institutions remains a challenging task.

Pediatrics

Q: When will the new pediatric guidelines be released? Until then, in our abstraction, must we use Goldstein or can we use the parameters that guide our providers now, such as PALS for hypotension?

Q: Will the pediatric advisory group be aligning with IPSO from the CHA?

Q: For clarity and ease of use, and since peds is so very different, wouldn't it behoove you to separate the dictionary into 2 different dictionaries...one for adult and one for pediatrics. That way is will be easier to use...for all.

Risk Adjustment

Q: Why isn't 'Chronic Respiratory Failure' included in the RA model?

Q: Have you ever considered adding obesity to the RA Model?

Q: Are the comorbidity variables only included in the Risk Adjusted Mortality model if the answer is 1) Present on Admission? Or are these variables included if the answer is 3) Present after adm but prior to severe sepsis & 4) Discovered after severe sepsis?

Q: Are you attributing improved mortality with bundle compliance? and if you are being there a statistical significance so you can do that?

Severity Adjustment Variable

Q: Does altered mental status refer to the 6-hour window or anytime during the patient's visit?

General Questions

Q: Do these changes you are speaking about finally align DOH and CMS? Can you delineate the differences?

Q: Will the presentation be available after the call?

Q: How do you validate that hospitals are submitting all of their cases?

Q: do you have data that shows utility of blood cultures in severe sepsis management? i.e. having them improves mortality?

Q: Do your validators understand that for SS/SS presentation time has 2 methods for determination: 1, by criteria and 2, by provider documentation, whichever is earlier? that may be why there is less concordance.

Q: regarding the future audits: will the DOH align with CMS/CDAC and identify where the mismatch occurred in record?

Q: I agree, there can be documentation of labs being drawn at one time, but the actual lab report has different time on the result. When the auditors review the record, there are so many different places we get data from and they may not be consistent with audit

Q: just throwing this out there. Now that there is an attempt to be consistent with CMS, why are we having to submit this data and not just use CMS data that is already being submitted?

Q: For patients who are excluded in the 3-hour window, will they also be excluded from the denominator for reporting, even if all 3-hour bundle elements are met.

Q: another comment with reporting CMS and NYS there is also a lot of resources being spent to do both, which NYS hospitals don't have the \$\$\$\$. Hospitals tend to follow CMS as that affects reimbursement!

Q: What does the DOH believe to be the best way to identify the cases to review? By ICD codes for Severe Sepsis or Septic Shock? Our providers are questioning this stating other facilities are not using this method to identify the population for review.

Q: Would it ever be possible to include a comments section on the abstraction where we could describe how we arrived at our presentation time? This can be a very involved, time consuming process and would make the validation process smoother.

February 2018 Q&A Session for NYSDOH Sepsis Abstractors Meeting

Q: Does the 5.1 include all the changes in the 5.0

Yes, version 5.1 does include the changes in version 5.0.

Q: Does this mean time zero will be arrival time, not triage time or time of recognition?

As of 1/1/2017, time zero refers to severe sepsis or septic shock presentation time. Criteria for the determination of these times are presented in the data dictionary. Details regarding whether severe sepsis or shock time is the time zero is dependent upon the measure. These details may be found in the measure specification documents found at https://ny.sepsis.ipro.org/files/Sepsis_measure_specifications_2017_Adults.pdf https://ny.sepsis.ipro.org/files/Sepsis_measure_specifications_2017_Peds.pdf

Q: When will the new pediatric guidelines be released? Until then, in our abstraction, must we use Goldstein or can we use the parameters that guide our providers now, such as PALS for hypotension?

The new pediatric guidelines are projected to be released toward the end of the year. PALS for hypotension can be used for now until the new recommendations are released.

Q: In CMS guidelines it lists being on antibiotics within 24 hours of presentation of severe or shock. Is this applicable to IPRO as well

Yes, it is.

Q: Will the pediatric advisory group be aligning with IPSO from the CHA?

The pediatric workgroup will be aligning with IPSO from the CHA if feasible. There are members of the IPSO collaborative participating in the workgroup.

Q: For clarity and ease of use, and since peds is so very different, wouldn't it behoove you to separate the dictionary into 2 different dictionaries...one for adult and one for pediatrics. That way is will be easier to use...for all.

Yes, we are currently discussing creating separate pediatric and adult data dictionaries when updated specifications are finalized. Thank you for your input.

Q: Do these changes you are speaking about finally align DOH and CMS? Can you delineate the differences?

Yes, most of the changes to the data elements align. Elements that are not aligned are documented in the data dictionary. For example, the DOH does not exclude fungal sources of infection. The DOH is looking for all cases of severe sepsis or shock regardless of the source. CMS has excluded reporting this type of infection source. Another way it varies is that the DOH and CMS use a different denominator. For example, CMS excludes cases outside of the 6-hour window identification window while the DOH is looking for all cases of severe sepsis or septic shock regardless of identification window.

Q: My apologies, you may have mentioned this but when will version 5.1 be available?

Version 5.1 is currently available.

Q: review the change r/t elevated lactates r/t other cause than sepsis.

The NYSDOH as of 1/1/2018 has a data element (elevated lactate reason) that allows reporting elevated lactate 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.

Q: Given that lactate 4 or > = septic shock, what constitutes severe sepsis? Therefore, would not all DOH inclusions be septic shock patients?

The Severe Sepsis definition is aligned with CMS SEP-1. Severe sepsis is defined as infection, two or more SIRS criteria, and organ dysfunction evidenced by criteria listed in the data dictionary. Septic shock is defined as severe sepsis plus persistent hypotension or tissue hypoperfusion evidenced by initial lactate level greater than or equal to 4. All cases reported to the portal are either severe sepsis or septic shock. The addition in the data element "elevated lactate reason" is not meant to change the definitions of either, it was added in response to hospitals reporting instances where a patient could have a lactic level greater than 4 and not be designated as having septic shock. It was simply to recognizing that there were instances where there was a lactate greater than or equal to 4 where patients had some underlying issue that caused the level to be elevated.

Q: Will the presentation be available after the call?

The presentation is available on the portal in power point slides and event recording.

Q: Has there been any discussion regarding the transfer patients? Abstraction from other institutions remains a challenging task.

We acknowledge this issue could be a challenge. We are looking for a solution on how to evaluate the transfer of patients and their entire episode of care. Please continue to report all cases regardless of sending or receiving transfer designation.

Q: What about viral causes, i.e. flu or RSV? do you advocate giving antibiotics to these patients?

No, DOH is not advocating giving antibiotics to patients with only viral infections.

Q: The Antibiotic selection variable does not account for monotherapy started before sepsis data time. There is no way to document that antibiotic monotherapy started before sepsis data time, as the variable antibiotic selection look at antibiotics given

Antibiotic selection refers to antibiotics administered within 3 hours after severe sepsis presentation time.

Q: Will the HANYS Sepsis reporting tool be updated to follow the new Data Dictionary? If so, when will this happen?

Please direct HANYS tool questions directly to HANYS.

Q: within 3 hours of the start datetime. How can we document that monotherapy was started before datetime, or is this considered a failure?

Priority: N/A-

The question is a little unclear. If a monotherapy broad spectrum antibiotic was administered within 24 hours before severe sepsis presentation then antibiotic selection is not required but you will need to report the antibiotic as having been given. If the antibiotic is given from the start time to within 3 hours, then antibiotic selection will be required.

Q: CMS excludes cases if patient on antibiotics > 24 hrs. So, this will be another non alignment?

We are collecting these cases but they will be excluded from the measures/bundles calculation if the antibiotics were administered 72 to 24 hours prior to severe sepsis. These cases will remain in the population of reported cases but not in the denominator for measures/bundles.

Q: So, if the elevated lactate is r/t another causes than sepsis, is the repeat lactate question excluded?

Currently it is not excluded but we will look at the possibility to exclude it in the future.

Q: So, are you indicating that for NYS, we should be reporting the date time of septic shock even if outside the 6-hour time window?

Yes, report datetime of shock as it is documented in the medical record.

Q: Please clarify on the difference between the definition of severe sepsis present in DOH and CMS. According to your dictionary, you are in alignment with the definition of CMS.

Both CMS and the DOH align with the definition of severe sepsis/septic shock.

Q: On the Data Element if a pt. is in Cardiogenic Shock will have a Lactate over 4. We will be able to document this? Am I understanding this correctly?

Data collection for 2018 forward allows for reporting when a lactate level over 4 could be caused by other reasons other than septic shock.

Q: hi. if the criteria were clinically met for severe sepsis, and if the sign from Organ dysfunction was lactate >4, and if there is no documentation of severe sepsis, will this be a septic shock case or severe sepsis case?

If the clinical criteria was met for severe sepsis and a patient had an initial lactate level > 4, it meets the criteria for shock.

Q: In the case of elevated lactic greater than 4, you definitely need a source of infection plus 2 or more of SIRS plus end organ which equals severe sepsis, so you can have cases of LA >4 but if it is not within the 6 hours of severe sepsis then you may not – The criteria for septic shock includes initial lactate greater than or equal to 4. The time of septic shock presentation in the scenario described is defined as follows in specifications

“If septic shock was determined by severe sepsis with elevated initial lactate of 4 or higher, use the later time of either severe sepsis presentation or when initial lactate result was available. (Not time drawn)”

It is true per specification that septic shock presentation must be within 6 hours of severe sepsis presentation.

Q: Why aren't CVAs/neurological conditions, trauma patients, and burn patients included in comorbidities?

Comorbidities are currently under review.

Q: Does DOH plan to align with CMS as far as "no exclusion" for fluid resuscitation?

There are currently no exclusions in CMS. Many NYS Sepsis Care Initiative participants advocated for clinical exclusions for fluid resuscitation, because a full fluid bolus may not be appropriate for all patients (fluid overload, CHF, renal failure). The exclusions are limited to extreme fluid overload, and there is no plan to change the exclusions at this time.

Q: is there any thought about adding a short free text field for comorbidities? In particular I would like to note when a patient is admitted with severe burns.

Good idea; we will take it into consideration.

Q: Why isn't 'Chronic Respiratory Failure' included in the RA model?

Variables in the RA model were selected based on their significance in statistics. If one variable is not included in the model, then it might be not as significant as other variables.

Q: Have you ever considered adding obesity to the RA Model?

Obesity is not currently a variable in the Sepsis Data Dictionary. Comorbidities are currently being analyzed.

Q: CMS excludes patients with severe sepsis/septic shock related to viral infections such as influenza. Are these patients with only documented influenza as the cause of severe sepsis/septic shock to be included or excluded in data collection and submission?

All cases of severe sepsis/shock should be included in the data collection and submission.

Q: Are the comorbidity variables only included in the Risk Adjusted Mortality model if the answer is 1) Present on Admission? Or are these variables included if the answer is 3) Present after adm but prior to severe sepsis & 4) Discovered after severe sepsis?

The options from the dictionary are: 0 = Not present on admission 1 = Present on admission 2 = Not known upon admission but discovered prior to presentation of severe sepsis 3 = Not known upon admission but discovered after the presentation of severe sepsis. For the RAMR, comorbidities reported as "1" or "2" were coded as a yes for comorbidity in modeling.

Q: Which time zero is this based on?

Please refer to the measure specifications of the discharge year you are asking about. For example, time zero/ start time is based on the datetime that severe sepsis or shock were identified either by documentation or by meeting the clinical criteria for 2017 measure specifications, based on which measure you are abstracting.

Q: Are you attributing improved mortality with bundle compliance? and if you are being there a statistical significance so you can do that?

No, we are not. Treatment variables were not used in the prediction model.

Q: How do you validate that hospitals are submitting all of their cases?

Multiple audits are conducted using a variety of data bases which are compared and analyzed. Based on the analysis we have been able to validate that the hospitals are submitting the majority of cases.

Q: do you have data that shows utility of blood cultures in severe sepsis management? i.e. having them improves mortality?

As per guidelines, blood cultures allow for de-escalation of antibiotic therapy when organism and susceptibilities are identified. De-escalation of antibiotics is a mainstay of antibiotic stewardship. Treatment variables were not used in the prediction model.

Q: Why are we doing fluid reassessment as part of the bundle? What is the scientific reasoning behind it?

Fluid status and perfusion reassessment is included in the bundle to align with CMS. The intent of the measure is to evaluate ongoing care for patients who have severe sepsis or septic shock and initial fluid resuscitation. We will continue to monitor the variable and discuss concerns with CMS.

Q: Do your validators understand that for SS/SS presentation time has 2 methods for determination: 1, by criteria and 2, by provider documentation, whichever is earlier? that may be why there is less concordance.

Yes, the validators are using this methodology to determine SS/SS presentation time. Thanks for checking!

Q: Since CMS allows the utilization of IBW to estimate volume of IVF required, is DOH allowing us to use ideal body weight as well? Also, since CMS is allowing the use of antibiotic fluid to be counted towards the 30 cc/kg, is this aligned as well?

Yes! IBW is aligned, and use of antibiotic fluid in calculating 30cc/kg fluid administration is also aligned with CMS.

Q: There is data showing flood patients with fluid can lead to ARDS and leads to increased mortality? How do you align that data with requiring fluid boluses for all patients?

A fluid bolus of 30cc/kg is included in measurement for patients with severe sepsis and hypotension or tissue hypoperfusion as evidenced by elevated lactic acid. CMS and NYSDOH guidelines provide data extraction options for bolus fluid administration. Ultimately the clinicians determine fluid bolus requirements for the patient. If the clinician determines that the targeted fluid volume is not appropriate for the patient, it needs to be clearly documented.

Q: regarding the future audits: will the DOH align with CMS/CDAC and identify where the mismatch occurred in record?

NYSDOH is evaluating where additional feedback from the audits would be feasible and beneficial in improving data accuracy.

Q: Do your auditors taken ventilator time from the flow sheets or from physician note because there are often time differences. Thank you

Ventilator time is abstracted from documentation when the patient was first intubated, which is not often clearly documented in the medical record. We are looking to validate time the hospital documented as the date time and look for the supportive documentation to validate the variable, but often the date/time does not align. Ventilator flow sheets, procedural notes, and MD notes are viewed to validate the variable.

Q: How about fluid from antibiotics? I do not see that in the data dictionary but CMS is allowing this volume of fluid to be used as of 2018. Thanks!

The NYSDOH aligned with CMS for fluid administration so you may follow CMS direction-

Q: I agree, there can be documentation of labs being drawn at one time, but the actual lab report has different time on the result. When the auditors review the record, there are so many different places we get data from and they may not be consistent with audit

The Data Dictionary documents abstraction instructions for date/time reporting for different variables and this is used during the audit. Please review the CMS and DOH guidelines for abstraction time for the laboratory tests.

Q: Can you clarify: Is the new data dictionary version 5.1 going back to January 1, 2018 discharges or is it for July 1st like CMS.

The 5.1 dictionary is in effect January 1, 2018. Thanks for asking.

Q: If we are aligned with CMS for antibiotic administration, If the patient has received antibiotics >24 hour prior to SS presentation. Do we need to continue to abstract the record? If so why?

Yes, you still need to abstract the data because data surrounding sepsis is an important part of analysis for mortality and other parameters surrounding sepsis.

Q: If patient complains of fever but on arrival to ED does not have fever, and has high lactate and one SIRS, which is suspected to be due to infection/sepsis can the fever at home be used in coming up with recognition time?

Recognition time is defined as the time that the last criterion was met to establish severe sepsis. This could include clinical criteria or physician documentation of severe sepsis. SIRS criteria include temperature >38.3 C or <36.0 C (>100.9 F or <96.8 F); a complaint of fever not otherwise specified, with normal temperature in ED, would not appear to meet the definition absent other documentation.

Q: just throwing this out there. Now that there is an attempt to be consistent with CMS, why are we having to submit this data and not just use CMS data that is already being submitted?

CMS does not collect data on all patients nor does CMS have a risk-adjusted mortality rate.

Q: Do your auditors taken ventilator time from the flow sheets or from physician note because there are often time differences. Thank you

Ventilator time is abstracted from documentation when the patient was first intubated which is not often clearly documented in the medical record. We are looking to validate time the hospital documented as the date time and look for the supportive documentation to validate the variable but often the date/time does not align.

Q: If we can use IBW, where does that get put so it's not confused? Is it just stated in the note: the physician will use ideal body weight and it is xx kg?

As per CMS specifications, the clinician may choose to use IBW to calculate fluids if a patient is obese (BMI > 30). For documentation:

"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.

The Clinician must clearly document that IBW will be the weight used to determine target ordered fluid volume.

Q: For patients who are excluded in the 3-hour window, will they also be excluded from the denominator for reporting, even if all 3-hour bundle elements are met.

If patients are excluded in the 3-hour window, they will be excluded from the denominator of the measures/bundles but they will still be in demographics/mortality/exclusions.

Q: My interpretation is if volume is given for the sake of fluid resuscitation, then you can use that volume for fluid administration

The NYSDOH aligned with CMS for fluid administration so you may follow CMS direction! -

Q: If the IBW is used, does it need to be identified with a number, or is "IBW" sufficient?

If the clinician is using IBW to calculate fluid requirement, it should be documented. The clinician must also document that the patient's IBW is being used to determine the target fluid requirement.

Q: i.e. Vancomycin is normally in 250ml bags, but the volume is not given for fluid resuscitation.... this should not be abstracted for fluid resuscitation

The NYSDOH aligned with CMS for fluid administration so you may follow CMS direction and can include fluids that have been used to dilute medication.

Q: How do you use 'vent time'?

Ventilation time is used as a risk adjustment variable relative to sepsis.

Q: on the other hand, if antibiotics are added to high volume fluids (1 L bags) and are given for fluid resuscitation, then they should be counted as fluid administration...

Yes

Q: For mechanical ventilation: This now includes vented patients as well as Bipap and Cpap (not for sleep apnea), correct??

That is correct. Do not abstract mechanical ventilation related to sleep apnea.

Q: what are you doing about flu and RSV? These are viral illnesses and many people meet SS/SS criteria, but those patient do not benefit from antibiotic? Your protocols suggest they should get them, when that is not appropriate.

No. The protocol does not suggest that antibiotics be given for viral illness. Hospitals are to report cases of severe sepsis or septic shock regardless of the source. At this point, the NYSDOH would like facilities to continue to report cases of severe sepsis or septic shock due to all infection sources.

Q: You had said there is a difference in severe sepsis between CMS and DOH whereas your dictionary states you are in alignment. Please clarify

The definition of severe sepsis is consistent between CMS and the DOH.

Q: another comment with reporting CMS and NYS there is also a lot of resources being spent to do both, which NYS hospitals don't have the \$\$\$\$. Hospitals tend to follow CMS as that effects reimbursement!

Q: Does altered mental status refer to the 6-hour window or anytime during the patient's visit?

Altered mental status refers to the difference in mental status at the time of the sepsis episode as compared to the patient's baseline. The sepsis episode is defined for this element as six hours before to six hours after the identification of severe sepsis and/or septic shock.

Q: What does the DOH believe to be the best way to identify the cases to review? By ICD codes for Severe Sepsis or Septic Shock? Our providers are questioning this stating other facilities are not using this method to identify the population for review.

There are many methods to identify cases for submission that facilities use to augment administrative code data. The DOH does not advocate one method over another but suggests that coding alone may not sufficiently capture all cases.

Q: When the antibiotics are administered greater than 24 hours prior to severe sepsis septic shock, how do we answer the blood culture question? CMS excludes these cases.

You can answer it by filling in the data element 'Blood Culture Acceptable Delay'.

Q: If we are supposed to submit cases of severe sepsis secondary to viral flu, how does this affect the bundle as viral flu patients do not receive antibiotics?

The NYS Sepsis Care Initiative includes patients presenting with severe sepsis and septic shock, that is, patients with sepsis and organ failure or sepsis and shock, for data collection and reporting.

Q: Is there a suggested IBW reference, or is the order for their fluid volume assumed to be correct? How do I know what their IBW is?

The Ideal Body Weight should be documented, as well as an indication that IBW will be used to calculate the fluid volume.

Q: For mechanical ventilation date/time, is that also for the 6-hour presentation window of for any time during the admission?

There is no presentation window for this particular comorbidity variable, but rather document the date and time the patient was first started on mechanical ventilation. This may be the time of arrival if the patient came in with mechanical ventilation.

Q: They are not all severely ill patients since now you are using a lactate > 2. For instance, a patient that has a lactate of 2.2 is not the same as one that has > 4.

We are aware that the severity of illness varies among patients as well as lactate levels. The value of >2 is used to establish organ dysfunction in severe sepsis and the initial lactate level greater than 4 could be a component for shock. As previously mentioned, we have taken into consideration increased lactate levels that are related to medications and other medical conditions.

Q: If a patient is admitted without respiratory failure but leaves the facility on mechanical ventilation, would that be considered + on the adult comorbidity? (Discovered after severe sepsis or Not present)?

It would be considered discovered after severe sepsis.

Q: If 'initial hypotension' = 'no', should we answer 'persistent hypotension' (as it refers to 'persistent or new onset hypotension')?

If initial hypotension is yes then you must answer persistent. If initial is no then you MAY still answer persistent because as you note, "new onset" is also included.

Q: Is antibiotic selection a pass/fail variable? is it a pass/fail for 3 hour bundle?

No. Antibiotic selection is used in measure 'Antibiotics administration' when antibiotics were administered after time zero.

Q: In CMS's specs organ dysfunction is described in more ways than just by the lactic acid and SBP<90. For example, the INR, platelet count, and total bilirubin. What does CMS say to this if the LA is normal but there are other signs of organ dysfunction as I

CMS and DOH are aligned for severe sepsis presentation. The specifications for organ dysfunction include the examples you cite are included in the DOH data dictionary as well. If the LA is normal but there other signs of organ dysfunction that meet criteria for severe sepsis, severe sepsis would be present.

Q: So you fail the bundle if antibiotics are given prior to the severe sepsis data time? This is related to antibiotic selection/severe sepsis datetime

No you do not. Antibiotics given 24 hours before until 3 hours after severe sepsis datetime can be abstracted. Antibiotic selection is relevant to antibiotics administered after severe sepsis presentation.

Q: Would it ever be possible to include a comments section on the abstraction where we could describe how we arrived at our presentation time? This can be a very involved, time consuming process and would make the validation process smoother.

Several hospitals requested the ability to submit focused medical records rather than the full medical record for audit selected cases. We are piloting this option right now. Similarly if hospitals would like to pilot sending additional documentation that assists in focusing the review during audit (such as comments on how presentation time was derived), we are open to this possibility. Please submit a helpdesk ticket and let us know that you wish to discuss and we will follow-up.

Q: I think it is very confusing regarding the antibiotics given within 24 hours prior to signs and symptoms of severe or shock. CMS lists this as an exclusion. Is it a total exclusion from following the protocol?

In 2017 measures specifications, if antibiotics were given within 24 hours prior to SS, it will not be excluded; if antibiotics were given 72 to 24 hours prior to SS, it will be excluded from the measure.

Q: How can you determine the 'time to vasopressors' if you don't collect the date/time that persistent hypotension began?

Septic shock presentation time is used to determine the time zero of vasopressors.