

OHA Sepsis Initiative – Data Entry FAQ

Data Access:

1. *Can a hospital have multiple data entry people? Can a hospital have multiple people have access to the data entry/report site?*

Yes. While try to limit number of people accessing the site, we recognize the need for additional people may need access. If you have multiple people who should have access to the data entry/report site, please email Rosalie Weakland at Rosalie.weakland@ohiohospitals.org.

Data Entry:

2. *Should data collection of the 3 hour bundle begin for June or July cases?*

Ideally data submission should begin with June cases or at least July's. Data is due AUGUST 15. Data can be collected either concurrently or retrospectively.

Sample Size:

3. *A minimum of 10 charts was requested- what is the recommendation for sample size (% of sepsis population)?*

You are correct the minimum sample size is 10 charts of all sepsis cases using the sepsis table in the data dictionary. Please refer to the table below for sampling strategy.

Monthly Sample Size Based on Hospital's Initial Patient Population Size for the Sepsis Measure Average Monthly Initial Patient Population Size N"	Minimum Required Sample Size "n"
≥ 101	20
51 - 100	20% of Initial Patient Population size
10 - 50	10
< 10	No sampling; 100% Initial Patient Population required

Population

4. *We have a question regarding the total population. We understand that the CMS population (all sepsis diagnoses) is going to be different than the population for this project (severe sepsis and septic shock). Is there a way that we can harmonize the data collection and minimize the burden once October comes? Obviously the CMS population will be larger and we would need to drill down on the two OHA diagnoses to submit our numerators and denominators?*

For the process measures OHA is using the same patient population as CMS to streamline things for abstract. This also permits you to evaluate how you are treating early sepsis and mitigate severe sepsis and septic shock. The ICD-9 codes have been added to the data dictionary.

5. *Will the OHA project be using the same definitions and codes as the CMS core measure, such as the exclusion criteria for determining cases for abstraction?*

Yes, OHA is using the same exclusion criteria and codes (ICD-9/ICD-10) as CMS process measure.

6. *Will OHA be revising the data dictionary before October when ICD-10 codes go into effect? The codes available on the CMS specs manual are only listed as ICD-10 codes.*

Yes, OHA will be revising the data dictionary for the October change to ICD-10. OHA will use the same ICD-10 codes as CMS for the process measures.

7. *You stated that **palliative care** was an exclusion for abstraction of the 3 hour bundle. Can you define the difference between DNR vs. Palliative Care?*

Palliative care within 3 hours of presentation of sepsis is an exclusion. Below is a clarification of palliative care/comfort care. In addition, other exclusions for the 3 hour bundle are listed.

Excluded Populations for 3 hour bundle:

- **Directive for Comfort Care within 3 hours of presentation of severe sepsis**

Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as "comfort care" by the general public.

It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Inclusion Guidelines for Abstraction:

- Brain dead
- Brain death
- Comfort care
- Comfort measures
- Comfort measures only (CMO)
- Comfort only
- DNR-CC
- End of life care
- Hospice
- Hospice care
- Organ harvest
- Terminal care
- Terminal extubation

- **Administrative contraindication to care**
- **Length of Stay >120 days**
- **Transfer in from another acute care facility**
- **Patients with severe sepsis who expire within 3 hours of presentation**

8. *What about **transfers to a tertiary center**? Does the receiving facility fail when treatments were not initiated prior to arrival which is very often?*

Transfers from another acute care facility are excluded from the sample.

9. *I have a question about the process measures and counting in the denominators. What if a patient was coded with one of the inclusion codes, say 995.92, but actually didn't have sepsis (never had organ failure). So they would never get to the questions that we need to answer. Would these patients be counted in the denominator, or would we just throw them entirely out?*

First, if they do not meet the criteria to be coded as 995.92 severe sepsis, you should have the chart recoded by your Medical Records Department. Based on the recoding would determine if they are included in the patient population or not.

10. ***Presentation Time**- our data analysis and comparisons to other collaborative hospitals will be skewed if hospitals are not using the CMS definitions for presentation time- which are different for ED presentation and admitted patients. Having clear operational definitions with an example would be helpful especially for hospitals that are just beginning to delve into the sepsis core measure. For example, if a patient comes in through the ED and meets the severe sepsis criteria then the ED Triage time is used as the Severe Sepsis Presentation Time. If a patient who is already admitted in the hospital meets the 3 criteria for severe sepsis then the time that the last criteria was met is used as the Severe Sepsis Presentation Time. Is the CMS criteria the same criteria that will be used for this OHA Sepsis Collaborative?*

OHA is using the same data definition as CMS is for presentation time. You are 2 different definitions for presentation time depending on location where sepsis was identified. If a patient comes in through the ED and meets the severe sepsis criteria then the ED Triage time is used as the Presentation Time. If a patient who is an inpatient meets the 3 criteria for severe sepsis then the time that the last criteria was met is used as the Presentation Time.

11. *Do you get credit for blood cultures regardless of antibiotic admin time?*

If the antibiotic is started at the same time as when the blood culture is drawn or given after the blood culture is drawn then you would answer "Yes". If the antibiotic is given before the blood culture is drawn answer "No".

12. ***Sepsis Three Hour Bundle Data Elements: Process Measures**- The first 3 sets of information to be entered (Lactate level, Blood culture, and Antibiotic) apply to all of the septic patients; however, according to the CMS algorithm, the Crystalloid Fluid Administration of 30 ml/kg only applies to patients who meet the septic shock criteria. The algorithm needs to be followed in order to determine if the patient meets the septic shock criteria. So will the numerator/ denominator for the Fluid Administration only include patients that meet the septic shock criteria and not all of the septic patients?*

You are correct, the first 3 elements ((Lactate level, Blood culture, and Antibiotic) apply to all of the septic patients and should be abstracted for all septic patients. If the patient is (hypotensive systolic blood pressure (SBP) < 90) or if lactate > 4.0 mmol, then abstract crystalloid fluid administration of 30 ml/kg. If the patient does not meet these 2 criteria then mark N/A and the patient will not be included for this measure.

13. *Does fluid administration have to be started within 3 hours or completed within 3 hours?*

To respond "Yes," the crystalloid fluids need to be started at 30 ml/kg within 3 hours. The recommendation is to give these fluids over 30 minutes. They do not need to be completed within the 3 hours.

14. *Are mortality rates risk adjusted?*

The mortality rates are not risk-adjusted at this time. We are looking into the possibility to risk-adjust the mortality measure in the future.