Midas DataVision and CPMS
Core Measures

Abstraction Guidelines for Inpatient Quality Measures (ED, IMM, SUB, TOB, VTE)

Excerpts from the Specifications Manual for National Hospital Inpatient Quality Measures, version 5.5a

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Acknowledgment


Midas Health Analytics Solutions
CONDUENT
4801 East Broadway Blvd, Suite 200
Tucson, Arizona 85711

(877) 414-2676

www.conduent.com

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Introduction to the Data Dictionary

Introduction
This section of the manual describes the data elements required to calculate category assignments and measurements for the national quality inpatient measures. It includes information necessary for defining and formatting the data elements, as well as the allowable values for each data element. This information is intended to assist in processing patient level data elements for national quality inpatient measures.

It is of primary importance that all hospitals using national quality inpatient measures gather and utilize the data elements as defined in this section. This will ensure that the data are standardized and comparable across hospitals.

Regardless of which measure sets are selected by a hospital, certain general data elements must be collected by the hospital and submitted for every patient that falls into any of the selected Initial Patient Populations. These data elements are considered “general” to each patient’s episode of care.

These data elements include:

- Admission Date
- Birthdate
- CMS Certification Number
- Discharge Date
- Health Care Organization Identifier
- Hispanic Ethnicity
- ICD-10-CM Other Diagnosis Codes
- ICD-10-PCS Other Procedure Codes
- ICD-10-PCS Other Procedure Dates
- ICD-10-CM Principal Diagnosis Code
- ICD-10-PCS Principal Procedure Code
- ICD-10-PCS Principal Procedure Date
- Measure Set
- National Provider Identifier
- Patient Identifier
- Payment Source
- Performance Measure Identifier
- Postal Code
- Race
- Sample
- Sex
- Vendor Tracking Identifier
Episode of Care
An Episode of Care (EOC) is defined as the health care services given during a certain period of time, usually during a hospital stay (e.g., from the day of arrival or admission to the day of discharge). The medical record should be abstracted as it was billed. In the event that there are multiple ED visits within the inpatient medical record, for the same episode of care, it is recommended that the ED visit resulting in the admission to observation or inpatient status be utilized for the purposes of abstraction.

If a patient is transferred from an acute care hospital to another acute care hospital, which is within the same healthcare system and share the same CMS Certification Number (CCN), this should be abstracted as one episode of care.

Data Integrity

Editing Zero Values
Verification mechanisms are necessary to assure that zero is the intended data value rather than an initialization value for those data elements which have an allowable value of zero (i.e., 0.0, 0000, 0).

Missing and Invalid Data
Each data element that is applicable per the algorithm for each of the measures within a measure set must be “touched” by the abstractor. While this is the expectation, it is recognized that in certain situations information may not be available (e.g., dates, times, codes, etc.). After due diligence in reviewing all allowable data sources within the medical record, if the abstractor determines that a value is not documented, i.e. “missing,” or is unable to determine if a value is documented, the abstractor should select the “UTD - Unable to Determine,” value. The data elements Admission Date, Discharge Date, and Birthdate require an actual date for submission into the CMS Clinical Warehouse and the Joint Commission’s Data Warehouse, and “UTD” cannot be selected as an allowable value. For Yes/No values the allowable value “No” incorporates the “UTD” into the definition. For data elements containing more than two categorical values and for numerical data elements (i.e., dates, times, laboratory values, etc.), a “UTD” option is included as an allowable value and is classified in the same category as not documented. Files that contain any invalid and/or missing data will be rejected from the CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. For additional details on the proper handling of missing and/or invalid data, please refer to the Missing and Invalid Data section of this manual.

Interpretation of Data Dictionary Terms
Data elements fall into four broad categories in order to support a specific measure set. They include:

- **General Data Elements** – data elements that must be collected by hospitals for each patient record
  - data elements required for each episode of care (EOC) record submitted
  - data elements used to identify the hospital on each patient record required for each patient-level record submitted
  - patient demographic data required for each episode of care record submitted and used for risk adjustment analysis (where applicable)
- **Measure Data Elements** – data elements used by one specific measure or several measures in two or more measure sets, such as **Discharge Disposition**
• Measure Set-Specific Data Elements – data elements used by one specific measure or several measures in one specific measure set, such as Alcohol Use Status in the SUB measures

• Algorithm Output Data Elements (The Joint Commission only) – Refer to ORYX® Technical guide

Data Element Dictionary Terms

Data Element Name: A short phrase identifying the data element. For ease of identification the data element name is italicized.

Collected For: Identifies the measure(s) and whether CMS or The Joint Commission utilize this data element or specifies that the data element is used for data transmission or verification.

Definition: A detailed explanation of the data element. A measurement system may include this information in data collection software.

Suggested Data Collection Question: A suggested wording for a data element question in a data abstraction tool.

Format: Length = number of characters or digits allowed for the data element

Type = type of information the data element contains (e.g., numeric, alphanumeric, date, character, or time)

Occurs = the number of times the data element occurs in a single episode of care record

Allowable Values: A list of acceptable responses for this data element.

Notes for Abstraction: Provided to assist abstractor in the selection of appropriate value for a data element.

Suggested Data Sources: Source document from which data may be identified such as administrative or medical record.

Guidelines for Abstraction: Designed to assist abstractors in determining how a data element should be answered.

Note: Element specific notes and guidelines should take precedence over the General Abstraction Guidelines.
**General Abstraction Guidelines**

The General Abstraction Guidelines are a resource designed to assist abstractors in determining how a question should be answered. The abstractor should first refer to the specific notes and guidelines under each data element. These instructions should take precedence over the following General Abstraction Guidelines. All of the allowable values for a given data element are outlined, and notes and guidelines are often included which provide the necessary direction for abstracting a data element. It is important to utilize the information found in the notes and guidelines when entering or selecting the most appropriate answer.

**Medical Record Documentation**

The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction. There are instances where an addendum or late entry is added after discharge. This late entry or addendum can be used, for abstraction purposes, as long as it has been added within 30 days of discharge, [Refer to the Medicare Conditions of Participation for Medical Records, 42CFR482.24(b)/42CFR482.24(c)(4)(viii)], unless otherwise specified in the data element. Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles (CMS "Medicare Program Integrity Manual" Chapter 3, Section 3.3.2.4):

- Clearly and permanently identify any amendments, corrections or addenda;
- Clearly indicate the date and author of any amendments, corrections, or addenda; and
- Clearly identify all original content.

It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.

Important Note: There are several data elements where abstraction of data from documentation dated/timed after discharge is restricted, and these exceptions are published on the respective data element pages of the data dictionary. Data element specific notes and guidelines always take precedence over the General Abstraction Guidelines.

Per the Medicare Conditions of Participation, all documentation in the medical record must be legible and must be timed, dated and authenticated [42CFR482.24(c)(1)]. However, documentation that is not timed, dated, or authenticated may still be used for abstraction if not required by the specific data element. When abstracting a medical record, if a handwritten document is determined to be not legible, other documentation should be reviewed in an attempt to obtain the answer. If no other source document is able to verify the handwritten documentation, only then is the abstractor to answer unable to determine from the medical record documentation, unless otherwise specified in the data element. Authentication may include written signatures, initials, computer key, or other codes.

Data element information should be retrieved from the current medical record, covering the admission and discharge date being abstracted. Information ascertainable from previous testing (e.g., left ventricular ejection fraction) or previous history (e.g., reason for not administering a medication) AND determined to be part of the current medical
record may be used in abstraction. As electronic data are available at all times during the hospitalization, it is acceptable to use this data for abstraction purposes. For example, if the patient had a previous left ventricular function assessment and this information is available in the current chart being abstracted (e.g., a note made in the progress notes, a previous echo report, or an electronic document), this information should be used.

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

Examples:

- Documentation indicates the **ED Departure Time** was 3300. No other documentation in the medical record provides a valid time. Since the **ED Departure Time** is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”

- Patient expires on 02-12-20XX and documentation indicates the **Septic Shock Presentation Date** was 03-12-20XX. Other documentation in the medical record supports the date of death as being accurate. Since the **Septic Shock Presentation Date** is after the **Discharge Date** (death), it is outside of the parameter of care and the abstractor should select “UTD.”

Please note that hospitals that are selected for validation will need to provide a paper or electronic (i.e. CD, DVD, or thumb drive) copy of the current medical record in its entirety, including all previous testing or history documents used in abstraction. If a hospital uses electronic data for abstraction and is unable to provide a paper or electronic copy of these data, and the record is chosen for validation, there is the potential for a mismatch to occur.

**Note:** Hospitals should use abbreviations according to their policy. Frequently flow sheets or other documentation contain a ‘key or legend’ that explains what the abbreviation or symbol stands for, especially if unique to that facility. If the record is selected for validation, it is not necessary to send your policy.

**Suggested Data Sources**

- Unless otherwise specified in the data element, the Suggested Data Sources are listed in alphabetical order, NOT priority order.

- Suggested Data Sources are designed to provide guidance to the abstractor as to the locations/sources where the information needed to abstract a data element will likely be found. However, the abstractor is not limited to these sources for abstracting the information and must review the entire medical record unless otherwise specified in the data element.

- In some instances, a data element may restrict the sources that may be used to gain the information, list a priority in which the sources should be used or may restrict documentation by only physician/advanced practice nurse/physician assistant. If so, these sources will be identified and labeled as “Excluded Data Sources,” “ONLY ACCEPTABLE SOURCES,” “Priority Source,” or “PHYSICIAN/APN/PA DOCUMENTATION ONLY.”
• If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select “Unable to Determine (UTD)” as the answer.
• Hospitals often label forms and reports with unique names or titles. Suggested Data Sources are listed by commonly used titles; however, information may be abstracted from any source that is equivalent to those listed. Example: If the “nursing admission assessment” is listed as a suggested source, an acceptable alternative might be titled “nurses initial assessment” or “nursing data base.”

Note:
Element specific notes and guidelines should take precedence over the General Abstraction Guidelines.

Inclusions/Exclusions
• Inclusions are “acceptable terms” that should be abstracted as positive findings (e.g., “Yes”).
• Inclusion lists are limited to those terms that are believed to be most commonly used in medical record documentation. The list of inclusions should not be considered all-inclusive, unless otherwise specified in the data element.
• Exclusions are “unacceptable terms” that should be abstracted as negative findings (e.g., “No”).
• Exclusion lists are limited to those terms an abstractor may most frequently question whether or not to abstract as a positive finding for a particular element (e.g., “cardiomyopathy” is an unacceptable term for heart failure and should be abstracted as "No"). The list of exclusions should not be considered all-inclusive, unless otherwise specified in the data element.
• When both an inclusion and exclusion are documented in a medical record, the inclusion takes precedence over the exclusion and would be abstracted as a positive finding (e.g., answer “Yes”), unless otherwise specified in the data element.

Physician/Advanced Practice Nurse/Physician Assistant Documentation
• Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialities. Some common titles that represent the advanced practice nurse role are:
  o Nurse Practitioner (NP)
  o Certified Registered Nurse Anesthetist (CRNA)
  o Clinical Nurse Specialist (CNS)
  o Certified Nurse Midwife (CNM)
• When a physician/advanced practice nurse/physician assistant (physician/APN/PA) signs a form or report (e.g., ED sheet with triage and nursing information and a physician/APN/PA has signed somewhere on the form), information on that form/report should be considered physician/APN/PA documentation.
• “Rubber” stamped physician/advanced practice nurse/physician assistant (physician/APN/PA) signatures are not acceptable on any document within the medical record. Handwritten, electronic signatures or facsimiles of original written or electronic signatures are acceptable.
• Resident and intern notes should be considered physician documentation. Medical student notes must be co-signed by a physician.
• For purposes of abstraction, telephone or verbal physician/APN/PA orders (TO/VO) in the medical record are considered physician/APN/PA documentation at the time they were written regardless of whether or not they were authenticated by the physician/APN/PA at the time of abstraction.

**Pharmacist Documentation**
Pharmacist titles may vary. Some common titles that represent the pharmacist role are:
• Doctor of Pharmacy (Pharm.D. or D.Ph.)
• Registered Pharmacist (R.Ph.)

**Medications**
• The approved medication tables contained in the dictionaries may not be inclusive lists of all available therapeutic agents acceptable for a particular data element. Discrepancies must be reported. See Appendix G (resource section) of this manual for contact information.
• Whether or not a medication has been administered to a patient is often clear when using medical record sources such as medication administration records, but documentation can be more ambiguous in other sources, namely, physician orders, ED records, and ambulance records. To make a determination using these sources, use the following criteria:
  o For EHRs, only accept documentation that reflects the actual administration of the medication in the context of the chart.
  o If a medication in the physician orders has been initialed and signed off with a time, do NOT presume that the medication was administered. The documentation MUST indicate that the medication was actually given.
  o For an ED or ambulance record, there is no need for documentation indicating that the medication was actually given.
    Example:
    If the ED or ambulance record reflects “ASA 325mg po 13:00” and no other documentation exists indicating that the medication was actually given (e.g., “given” or “administered”), this is acceptable documentation to abstract.
• When determining whether or not a patient was discharged on a specific medication (e.g., a beta-blocker):
  o If discharge medications are noted using only references such as “continue home meds,” “continue previous medications,” “resume other meds,” “same medications,” or “continue meds,” rather than lists of the names of the discharge medications, the abstractor should select “Yes” if the patient was on the medication in question prior to arrival (or in the case of transfers from acute care hospitals, if the patient was on the medication in question prior to arrival at the first acute care hospital), unless documentation suggests otherwise.
If discharge medications are noted using only references such as “continue current medications” or “continue present meds” rather than lists of the names of the discharge medications, the abstractor should select “Yes” if the medication in question was listed as a medication on the day of discharge, unless documentation indicates it was to be discontinued at discharge or suggests otherwise.

If discharge medications are noted using general references such as “continue home meds,” “continue previous medications,” “continue current meds,” “continue present meds,” “resume other meds,” or “continue meds,” but a list of the names of the discharge medications also in the record gives conflicting information about what medications the patient was actually discharged on, the abstractor should consider the list most accurate and use only the list in determining whether or not a patient was discharged on a specific medication.

Hospitals may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patient’s own medications brought into the hospital. Hospitals must document the administration of each medication, as reported by the patient (or the patient’s caregiver/support person where appropriate), in the patient’s medical record [42CFR482.23(c)(6)].

Nursing Care Plans, Standing Orders and Protocols

- Per Medicare Conditions of Participation [42CFR482.23(b)(4)] hospitals have the option of having a stand-alone nursing care plan or a single interdisciplinary care plan that addresses nursing and other disciplines.
- Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders if such orders and protocols are dated, timed, and authenticated promptly in the patient’s medical record by the ordering practitioner responsible for the care of the patient [42CFR482.24(c)(3)].

Diagnostic/Laboratory Tests

Whether or not a diagnostic or laboratory test has been done is usually clear when using medical record sources such as diagnostic test reports, laboratory reports, or progress notes (where a physician might note test findings), but documentation can be more ambiguous in other sources, namely, physician orders and ED records. To make a determination using these sources, use the following criteria:

- If a test in the physician orders has been initialed and signed off with a time, do NOT presume that the test was done. The documentation MUST indicate that the test was actually done (e.g., accompanied by a word such as “done”).
- For an ED record, there is no need for explicit documentation indicating that the test was actually done. For example, if an ED record notes “Lactate Level,” and this is followed by a signature and/or a time, the abstractor should presume the test was performed.

Grids

Instructions for reading values recorded on grids: Measure from the midpoint of the symbol, number and letter. If the value falls between two lines on the grid, abstract the earliest value.
Alphabetical Data Dictionary

The General Abstraction Guidelines explain the different sections of the data element definitions and provide direction for common questions and issues that arise in medical record abstraction. Instructions in the specific data elements in this Data Dictionary should **ALWAYS** supersede those found in the General Abstraction Guidelines.

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**Data Element Name:** Administrative Contraindication to Care, Septic Shock

**Collected For CMS:** SEP-1

**Definition:** Documentation of refusal of blood draw, IV fluid administration, or vasopressor administration prior to or within 6 hours following presentation of septic shock.

**Suggested Data Collection Question:** Is there documentation that the patient or authorized patient advocate refused either a blood draw, IV fluid administration, or vasopressor administration prior to or within 6 hours following the Septic Shock Presentation Time?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **1 (Yes)**: There is documentation by a physician/APN/PA or nurse that the patient or authorized patient advocate has refused either blood draw, IV fluid administration, or vasopressor administration prior to or within 6 hours following presentation of septic shock.
- **2 (No)**: There is no physician/APN/PA or nurse documentation that the patient or authorized patient advocate has refused either blood draw, IV fluid administration, or vasopressor administration prior to or within 6 hours following presentation of septic shock.

**Notes for Abstraction:**
- Only acceptable sources are physician/APN/PA or nursing documentation.
- Specific documentation indicating patient or authorized patient advocate has refused the following can be used to select Value “1.”
  - Blood draws
  - IV or IO fluid administration
  - Vasopressors
- A more general documentation of refusal of care (e.g. central line, PICC, IO access) that would result in the following not being administered is acceptable.
  - Blood Draws
  - IV or IO fluid administration
  - 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).
• An authorized patient advocate is someone (defined by facility policy) who is authorized to make decisions on behalf of the patient when the patient is not able to.

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

Suggested Data Sources:
• Consultation reports
• History and physical
• Nursing Notes
• Physician/APN/PA notes

Inclusion Guidelines for Abstraction:
• Declined
• Does not want
• Refused
• Requests not to be given

Exclusion Guidelines for Abstraction:
None
Data Element Name: Administrative Contraindication to Care, Severe Sepsis

Collected For CMS: SEP-1

Definition: Documentation of refusal of blood draw, IV fluid administration, or IV antibiotic administration prior to or within 6 hours following presentation of severe sepsis.

Suggested Data Collection Question: Is there documentation that the patient or authorized patient advocate refused either a blood draw, IV fluid administration, or IV antibiotic administration prior to or within 6 hours following the Severe Sepsis Presentation Time?

Format:
   - Length: 1
   - Type: Alphanumeric
   - Occurs: 1

Allowable Values:
1 (Yes) There is documentation by a physician/APN/PA or nurse that the patient or authorized patient advocate has refused either blood draw, IV fluid administration, or IV antibiotic administration prior to or within 6 hours following presentation of severe sepsis.

2 (No) There is no physician/APN/PA or nurse documentation that the patient or authorized patient advocate has refused either blood draw, IV fluid administration, or IV antibiotic administration prior to or within 6 hours following presentation of severe sepsis.

Notes for Abstraction:
- Only acceptable sources are physician/APN/PA or nursing documentation.
- Specific documentation indicating patient or authorized patient advocate has refused the following can be used to select Value “1.”
  - Blood draws
  - IV or IO fluid administration
  - IV or IO antibiotic
- A more general documentation of refusal of care that would result in the following not being administered is acceptable.
  - Blood draws
  - IV or IO fluid administration
  - IV or IO antibiotic
- 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).
• An authorized patient advocate is someone (defined by facility policy) who is authorized to make decisions on behalf of the patient when the patient is not able to.

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

**Suggested Data Sources:**
- Consultation reports
- History and physical
- Nursing Notes
- Physician/APN/PA notes

**Inclusion Guidelines for Abstraction:**
- Declined
- Does not want
- Refused
- Requests not to be given

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Admission Date

Collected For CMS/The Joint Commission: All Records

Definition: The month, day, and year of admission to acute inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?

Format:
- **Length:** 10 – MM-DD-YYYY (includes dashes)
- **Type:** Date
- **Occurs:** 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)

Note: For CMS, only dates that are equal to or less than 120 days from the Discharge Date will be accepted into the CMS Clinical Warehouse. Refer to the Data Transmission section of this manual for further guidance related to data transmission.

Notes for Abstraction:
- The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date from billing is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- If using claim information, the ‘Statement Covers Period’ is not synonymous with the ‘Admission Date’ and should not be used to abstract this data element. These are two distinctly different identifiers:
  - The Admission Date is purely the date the patient was admitted as an inpatient to the facility.
  - The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included in a particular claim. The “From” Date is the earliest date of service on the claim.
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.
  - Example:
    Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The Admission Date would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.
• The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

Example:
Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The Admission Date would be abstracted as 05-01-20xx.

• If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.

• For newborns that are born within this hospital, the Admission Date would be the date the baby was born.

Suggested Data Sources:
Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the Admission Date.

ONLY ALLOWABLE SOURCES:
1. Physician orders
2. Face Sheet
3. UB-04

Excluded Data Sources:
UB-04 “From” and “Through” dates

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
• Admit to observation
• Arrival date
Data Element Name: Alcohol Use Status

Collected For The Joint Commission Only: All SUB Measures

Definition: 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). A validated screening questionnaire is an instrument that has been psychometrically tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition). Validated screening questionnaires can be administered by pencil and paper, by computer or verbally. The screening questionnaire should be at a comprehension level or reading level appropriate for the patient population and in the appropriate language for non-English speaking patients.

An example of a validated questionnaire for alcohol screening is the 10 item Alcohol Use Disorder Identification Tests (AUDIT). The first three questions of the AUDIT, the AUDIT-C, ask about alcohol consumption, and can be used reliably and validly to identify unhealthy alcohol use. The four-item CAGE questionnaire is generally inappropriate for screening general populations, as it aims to identify only severely alcohol dependent patients.

Suggested Data Collection Question: What is the patient’s alcohol use status?

Format:
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

Allowable Values:

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 within 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 within the first day of admission (by end of Day 1) because of cognitive impairment.

Notes for Abstraction:

- 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.
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.

**EXCEPTION:**
If there is documentation of a validated questionnaire for alcohol screening completed within the first day of admission, select the appropriate Value 1 or 2 regardless of conflicting documentation.

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.

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 within the first day of admission (by end of Day 1) that the patient was psychotic, symptoms of psychosis, e.g., hallucinating, non-communicative, catatonic, etc., must also be documented for the patient to be considered cognitively impaired.

If there is documentation to “rule out” a condition/diagnosis related to cognitive impairment, Value “7” cannot be selected unless there is documentation of symptoms.

**Examples:**
- Patient actively hallucinating, rule out psychosis. (Select Value “7”).
- Rule out psychosis. (Cannot 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:
- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive impairment
- Cognitively impaired
- Cognitive impairment due to acute substance use, overdose, acute intoxication
- Confused
- Dementia
- Intubation
- Memory loss
- Mentally handicapped
- Obtunded
- Psychotic/psychosis with documented symptoms
- Sedation

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 appropriately screened and subsequently counseled due to cognitive impairment. Select Value “7.”
Suggested Data Sources:
- Consultation notes
- Emergency Department record
- History and physical
- Nursing admission assessment
- Nursing admission notes
- Physician progress notes

Inclusion Guidelines for Abstraction:
Validated Screening Tools for Unhealthy Alcohol Use:
This list is not ALL Inclusive
- AUDIT
- AUDIT-C
- ASSIST
- CRAFFT
- G-MAST
- MAST
- TWEAK

Exclusion Guidelines for Abstraction:
Any tool which specifically screens for alcohol use disorder, alcohol dependency or alcohol abuse. Examples include, but are not limited to:
- CAGE
- SASSI
- S2BI
Data Element Name: *Arrival Date*

Collected For The Joint Commission **Only:** ED-1

**Definition:** The earliest documented month, day, and year the patient arrived at the hospital.

**Suggested Data Collection Question:** What was the **earliest** documented date the patient arrived at the hospital?

**Format:**
- **Length:** 10 – MM-DD-YYYY (includes dashes) or UTD
- **Type:** Date
- **Occurs:** 1

**Allowable Values:** Enter the earliest documented date
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

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

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

**Note:** Transmission of a case with an invalid date as described above will be rejected from the CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *Arrival Date* allows the case to be accepted into the warehouse.
• Review the Only Acceptable Sources to determine the earliest date the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.

• Documentation outside of the Only Acceptable Sources list should NOT be referenced (e.g., ambulance record, physician office record, H&P).

**Examples:**
- ED Triage Date/Time 03-22-20xx 2355. ED rhythm strip dated/timed 03-23-20xx 0030. EMS report indicates patient was receiving EMS care from 0005 through 0025 on 03-23-20xx. The EMS report is disregarded. Enter 03-22-20xx for *Arrival Date*.
- ED noted arrival time of 0100 on 04-14-20xx. Lab report shows blood culture collected at 2345 on 04-13-20xx. It is not clear that the blood culture was collected in the ED because the lab report does not specify it was collected in the ED (unable to confirm lab report as an Only Acceptable Source). Enter 04-14-20xx for *Arrival Date*.
- ED Triage Date/Time 06-18-20xx 0025. EMS report indicates patient arrived by ambulance on 06-17-20xx 2355. Patient routed directly to CT. The EMS report is disregarded. Enter 06-18-20xx for *Arrival Date*.

• Arrival date should NOT be abstracted simply as the earliest date in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest date documented appears to be an obvious error, this date should not be abstracted.

**Examples:**
- ED arrival time noted as 0030 on 10-29-20xx. ED MAR shows an antibiotic administration time of 0100 on 10-28-20xx. Surrounding documentation on the ED MAR makes clear that the 10-28-20xx date is an obvious error - Date was not changed to 10-29-20xx. The antibiotic administration date/time would be converted to 0100 on 10-29-20xx. Enter 10-29-20xx for *Arrival Date*.
- ED MAR shows an antibiotic administration time of 1430 on 11-03-20xx. All other dates in the ED record note 12-03-20xx. The antibiotic administration date of 11-03-20xx would not be used for *Arrival Date* because it is an obvious error.
- ED ECG dated/timed as 05-07-20xx 2142. ED Greet Date/Time 05-08-20xx 0125. ED Triage Date/Time 05-08-20xx 0130. There is no documentation in the Only Acceptable Sources which suggests the 05-07-20xx is an obvious error. Enter 05-07-20xx for *Arrival Date*.
- ED RN documents on a nursing triage note dated 04-24-20xx, “Blood culture collected at 2230.” ED arrival time is documented as 0130 on 04-25-20xx. There is no documentation in the Only Acceptable Sources which suggests the 04-24-20xx is an obvious error. Enter 04-24-20xx for *Arrival Date*. 
• The source “Emergency Department record” includes any documentation from the time period that the patient was an ED patient (e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, ED triage record, ED physician orders, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, ED x-ray reports, ED head CT scan, CTA, MRI, MRA reports).

• The source “Procedure notes” refers to procedures such as cardiac caths, endoscopies, and surgical procedures. Procedure notes do not include ECG and x-ray reports.

• The arrival date may differ from the admission date.

• If the patient is in either an outpatient setting of the hospital other than observation status (e.g., dialysis, chemotherapy, cardiac cath) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the date the patient arrived at the ED or on the floor for acute inpatient care as the arrival date.

• Observation status:
  o If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care as the arrival date.
  o If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED as the arrival date.

• Direct Admits:
  o If the patient is a “Direct Admit” to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date.
  o For “Direct Admits” to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the Only Acceptable Sources) as the arrival date.

• If the patient was transferred from your hospital’s satellite/free-standing ED or from another hospital within your hospital’s system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date at the first facility.

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES:
• Emergency Department record
• Nursing admission assessment/admitting note
• Observation record
• Procedure notes
• Vital signs graphic record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Addressographs/Stamps
Data Element Name: *Arrival Time*

Collected For The Joint Commission Only: ED-1

**Definition:** The earliest documented time (military time) the patient arrived at the hospital.

**Suggested Data Collection Question:** What was the earliest documented time the patient arrived at the hospital?

**Format:**
- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

**Allowable Values:** Enter the earliest documented time of arrival

- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

**Examples:**
- Midnight - 00:00
- Noon - 12:00
- 5:31 am - 05:31
- 5:31 pm - 17:31
- 11:59 am - 11:59
- 11:59 pm - 23:59

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Arrival Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Arrival Date*.

**Example:**
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

**Notes for Abstraction:**
- For times that include “seconds,” remove the seconds and record the time as is.
  **Example:**
  15:00:35 would be recorded as 15:00.
- If the time of arrival is unable to be determined from medical record documentation, select “UTD.”
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”
Example:
Documentation indicates the Arrival Time was 3300. No other documentation in the list of Only Acceptable Sources provides a valid time. Since the Arrival Time is outside of the range in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”

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

- Review the Only Acceptable Sources to determine the earliest time the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.
- Documentation outside of the Only Acceptable Sources list should NOT be referenced (e.g., ambulance record, physician office record, H&P).

Examples:
- ED Triage Time 0800. ED rhythm strip 0830. EMS report indicates patient was receiving EMS care from 0805 through 0825. The EMS report is disregarded. Enter 0800 for Arrival Time.
- ED noted arrival time of 0945. Lab report shows blood culture collected at 0830. It is not clear that the blood culture was collected in the ED because the lab report does not specify it was collected in the ED (unable to confirm lab report as an Only Acceptable Source). Enter 0945 for Arrival Time.
- ED Triage Time 1525. EMS report indicates patient was receiving care 1435 through 1455. ED report documents time of head CT 1505. The EMS report is disregarded. Enter 1505 for Arrival Time.
- Arrival time should NOT be abstracted simply as the earliest time in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest time documented appears to be an obvious error, this time should not be abstracted.

Examples:
- ED arrival time noted as 2300 on 10-28-20xx. ED MAR shows an antibiotic administration time of 0100 on 10-28-20xx. Surrounding documentation on the ED MAR makes clear that the 10-28-20xx date is an obvious error - Date was not changed to 10-29-20xx. The antibiotic administration date/time would be converted to 0100 on 10-29-20xx. Enter 2300 for Arrival Time.
- ED face sheet lists arrival time of 13:20. ED Registration Time 13:25. ED Triage Time 13:30. ED consent to treat form has 1:17 time but “AM” is circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 13:20 for Arrival Time.
- ED ECG timed as 1742. ED Greet Time 2125. ED Triage Time 2130. There is no documentation in the Only Acceptable Sources which suggests the 1742 is an obvious error. Enter 1742 for Arrival Time.
ED RN documents on the nursing triage note, “Blood culture collected at 0730.” ED arrival time is documented as 1030. There is no documentation in the Only Acceptable Sources which suggests the 0730 is an obvious error. Enter 0730 for Arrival Time.

- The source “Emergency Department record” includes any documentation from the time period that the patient was an ED patient (e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, ED triage record, ED physician orders, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, ED x-ray reports, ED head CT scan, CTA, MRI, MRA reports).
- The source “Procedure notes” refers to procedures such as cardiac caths, endoscopies, and surgical procedures. Procedure notes do not include ECG and x-ray reports.
- The arrival time may differ from the admission time.
- If the patient is in either an outpatient setting of the hospital other than observation status (e.g., dialysis, chemotherapy, cardiac cath) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the time the patient arrived at the ED or on the floor for acute inpatient care as the arrival time.
- Observation status:
  - If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care as the arrival time.
  - If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED as the arrival time.
- Direct Admits:
  - If the patient is a “Direct Admit” to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time.
  - For “Direct Admits” to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the Only Acceptable Sources) as the arrival time.
- If the patient was transferred from your hospital’s satellite/free-standing ED or from another hospital within your hospital’s system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility.

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES:
- Emergency Department record
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Addressographs/stamps
Data Element Name: Birthdate

Collected For CMS/The Joint Commission: All Records

Definition: The month, day, and year the patient was born.

Note: Patient's age (in years) is calculated by Admission Date minus Birthdate. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.

Suggested Data Collection Question: What is the patient’s date of birth?

Format:
- Length: 10 – MM-DD-YYYY (includes dashes)
- Type: Date
- Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (1880-Current Year)

Notes for Abstraction:
Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:
- Emergency Department record
- Face sheet
- Registration form
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: **Blood Culture Collection**

Collected For CMS: SEP-1

Definition: Documentation of the collection of a blood culture.

Suggested Data Collection Question: Was a blood culture collected in the appropriate time window?

Format:
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

Allowable Values:
- 1 (Yes) A blood culture was collected in the appropriate time window.
- 2 (No) A blood culture was not collected in the appropriate time window or unable to determine.

Notes for Abstraction:
- If a patient **does not** receive an IV or IO antibiotic within the 24 hours before the presentation of severe sepsis, the appropriate time window is:
  - 24 hours prior to Severe Sepsis Presentation Date and Time through 3 hours following Severe Sepsis Presentation Date and Time.
- If a patient **does** receive an IV or IO antibiotic within the 24 hours before the presentation of severe sepsis, the appropriate time window is:
  - 24 hours prior to the administration of the antibiotic through 3 hours following Severe Sepsis Presentation Date and Time.
- Use documentation specifying a blood culture was actually drawn or collected. Do not use “Labs Drawn” or similar documentation, as it is not specific to blood culture.
- If a blood culture is ordered and there is an attempt to collect it, but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, select Value “1.”
- If there is supportive documentation that a blood culture was collected in the appropriate time window and it is the earliest mention of a blood culture, this date and time can be used, e.g., “BC sent to lab,” “blood culture received time.” Select Value “1.”
- Do not use physician orders to determine a blood culture was collected, as they do not demonstrate collection of the blood culture.

Suggested Data Sources:
- Emergency Department record
- History and physical
- Laboratory report
- Microbiology report
- Nursing notes
- Physician/APN/PA Progress notes
Inclusion Guidelines for Abstraction:

• BC
• Blood cultures
• Blood cultures collected

Exclusion Guidelines for Abstraction:

• Blood sent to lab
• Lab here
• Labs drawn
Data Element Name: *Blood Culture Collection Acceptable Delay*

Collected For CMS: SEP-1

**Definition:** Documentation supporting there was an acceptable delay in the collection of a blood culture.

**Suggested Data Collection Question:** Is there documentation supporting an acceptable delay in collecting a blood culture?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- 1 (Yes) There is documentation supporting an acceptable delay in the collection of a blood culture.
- 2 (No) There is no documentation supporting an acceptable delay in the collection of a blood culture.

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

**Examples:**
- ED Physician Note: Patient condition worsening, IV Vanco ordered stat, blood and urine cultures ordered, awaiting CXR.
- Hospitalist Progress Note: Patient’s deteriorating condition concern for rapidly advancing infection, starting IV antibiotics now, lab on way to collect blood cultures.
- Obstetric patients given prophylactic antibiotics for ruptured membranes, group B strep, or prior to a caesarean section.

- If there is no documentation supporting an acceptable delay in the collection of a blood culture, choose Value “2.”
Suggested Data Sources:
- Emergency Department record
- History and physical
- Laboratory report
- Medication Administration Records
- Microbiology report
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Oral (PO) Antibiotics
Data Element Name: Blood Culture Collection Date

Collected For CMS: SEP-1

Definition: The date on which a blood culture was collected within the appropriate time window.

Suggested Data Collection Question: What date was the blood culture collected on?

Format:
- **Length:** 10 – MM-DD-YYYY (includes dashes) or UTD
- **Type:** Date
- **Occurs:** 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

Notes for Abstraction:
- Refer to the Blood Culture Collection data element for the appropriate time window to abstract this data element.
- Use documentation specifying a blood culture was actually drawn or collected. Do not use “Labs Drawn” or similar documentation, as it is not specific to the blood culture.
- If there is supportive documentation that a blood culture was collected in the appropriate time window and it is the earliest mention of a blood culture, this date can be used, e.g., “BC sent to lab,” “blood culture received time.”
- Do not use physician orders to determine that a blood culture was collected, as they do not demonstrate collection of the blood culture.
- In the event there is a failure to collect the blood culture specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, abstract the date at which the unsuccessful attempt was carried out.
- Stop abstracting 3 hours after the presentation of severe sepsis.
- If multiple blood cultures were drawn or attempted, abstract the earliest blood culture drawn or attempted in the appropriate time window.

Suggested Data Sources:
- Laboratory documentation
- Nursing notes
- Physician/APN/PA Progress Notes

Inclusion Guidelines for Abstraction:
- Blood culture drawn
- Blood culture to lab
- Blood culture received
Exclusion Guidelines for Abstraction:

- Blood sent to lab
- Lab here
- Labs drawn
Data Element Name: *Blood Culture Collection Time*

Collected For CMS: SEP-1

Definition: The time at which a blood culture was collected within the appropriate time window.

Suggested Data Collection Question: What time was the blood culture collected?

Format:
- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight – 00:00
- Noon – 12:00
- 5:31 am – 05:31
- 5:31 pm – 17:31
- 11:59 am – 11:59
- 11:59 pm – 23:59

Notes for Abstraction:
- Please refer to the *Blood Culture Collection* data element for the appropriate time window to abstract this data element.
- Use documentation specifying a blood culture was actually drawn or collected. Do not use “Labs Drawn” or similar documentation, as it is not specific to the blood culture.
- If there is supportive documentation that a blood culture was collected in the appropriate time window and it is the earliest mention of a blood culture, this time can be used, e.g., “BC sent to lab,” “blood culture received time.”
- Do not use physician orders to determine that a blood culture was collected, as they do not demonstrate collection of the blood culture.
- In the event there is a failure to collect the blood culture specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, please abstract the time at which the unsuccessful attempt was carried out.
- Stop abstracting 3 hours after the presentation of severe sepsis.
- If multiple blood cultures were drawn or attempted, abstract the earliest blood culture drawn or attempted in the appropriate time window.
Suggested Data Sources:
- Laboratory documentation
- Nursing notes
- Physician/APN/PA Progress Notes

Inclusion Guidelines for Abstraction:
- Blood culture drawn
- Blood culture received
- Blood culture to lab

Exclusion Guidelines for Abstraction:
- Blood sent to lab
- Lab here
- Labs drawn
Data Element Name: Brief Intervention

Collected For The Joint Commission Only: SUB-2

Definition: A brief intervention is a single session or multiple sessions conducted by a qualified healthcare professional or trained peer support person, following a positive screen for unhealthy alcohol use. The intervention includes motivational discussion focused on increasing insight and awareness regarding alcohol use and motivation toward behavioral change. Brief interventions can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at risk as well as a vehicle for engaging those in need of more extensive levels of care.

A brief intervention focuses on increasing the patient’s understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to.

Suggested Data Collection Question: Did patients with a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence) receive a brief intervention prior to discharge?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1. The patient received the components of a brief intervention.
2. The patient refused/declined the brief intervention.
3. Brief counseling was not offered to the patient during the hospital stay or unable to determine if a brief intervention was provided from medical record documentation.

Notes for Abstraction:
- A qualified healthcare professional may be defined as a physician, nurse, certified addictions counselor, psychologist, social worker, or health educator with training in brief intervention.
- A peer support person who has received specialized training in brief intervention may perform the brief intervention in lieu of a qualified healthcare professional.
- If there is no documentation that a brief intervention was given to the patient, select Value “3.”
• Select Value “3” if the documentation provided is not explicit enough to determine if the intervention provided contained the specific components or if it is determined that the intervention does not meet the intent of the measure.

• A brief intervention includes, at a minimum, the following three components:
  a. Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems
  b. Feedback linking alcohol use and health, including:
     - Personalized feedback (i.e., explaining how alcohol use can interact with patient’s medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications])
     OR
     - General feedback on health risks associated with drinking.
  c. Advice:
     - To abstain (if there are contraindications to drinking)
     OR
     - To drink below recommended limits (specified for patient).

Suggested Data Sources:
• Consultation notes
• Nursing notes
• Physical progress notes
• Progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Broad Spectrum or Other Antibiotic Administration

Collected For CMS: SEP-1

Definition: Documentation of administration of a broad spectrum or other antibiotic in the time window 24 hours prior to or 3 hours after Severe Sepsis Presentation Date and Time.

Suggested Data Collection Question: 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?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- 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.

Notes for Abstraction:
- 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.”
- 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.
- 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.
• 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:
  o Pre-Op Checklist states:
    ▪ IV Started at 1730
    ▪ Preop Antibiotic Given at 1800
  o Operative report states:
    ▪ IV antibiotics were given prior to procedure.
    ▪ IV antibiotics given at 0900 prior to incision.

• Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified time frame.
• If the antibiotic name, route, date or time is missing, disregard that dose.
• Pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record should be used for abstracting antibiotics.

Suggested Data Sources:
• Anesthesia record
• Entire Emergency Department record
• ICU flow sheet
• IV flow sheet
• Medication administration record
• Nurses notes
• Operating room record
• PACU/recovery room record
• Perfusion record
• Physician/APN/PA notes
• Pre-arrival documentation that is part of the medical record

Inclusion Guidelines for Abstraction:
• Antibiotic administered via intravenous route
• Intramuscular or IM
• Intraoosseous or IO
• Intravenous
• IV Bolus
• IV infusion

Exclusion Guidelines for Abstraction:
• Give antibiotic stat
• Hang antibiotic
• Order for xx antibiotic
Data Element Name: Broad Spectrum or Other Antibiotic Administration Date

Collected For CMS: SEP-1

Definition: 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.

Suggested Data Collection Question: 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?

Format:
- Length: 10 – MM-DD-YYYY (includes dashes) or UTD
- Type: Date, Numeric
- Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

Notes for Abstraction:
- 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></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></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></td>
<td>First dose of D</td>
</tr>
<tr>
<td>E</td>
<td></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 E</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:
  o A physician order for IV antibiotics is not sufficient unless the antibiotic ordered was marked as “started” with date/time noted.
  o 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 time frame.

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.

Suggested Data Sources:
• Anesthesia record
• Entire Emergency Department record
• ICU flow sheet
• IV flow sheet
• Medication administration record
• Nurses notes
• Operating room record
• PACU/recovery room record
• Perfusion record
• Physician/APN/PA notes
• Pre-arrival documentation that is part of the medical record

**Inclusion Guidelines for Abstraction:**

• Antibiotic administered via intravenous route
• Intramuscular or IM
• Intraosseous or IO
• Intravenous
• IV Bolus
• IV infusion

**Exclusion Guidelines for Abstraction:**

• Give antibiotic stat
• Hang antibiotic
• Order for xx antibiotic
Data Element Name: Broad Spectrum or Other Antibiotic Administration Selection

Collected For CMS: SEP-1

Definition: The selection of the antibiotic administered within 3 hours following Severe Sepsis Presentation Date and Time.

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

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
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.

Notes for Abstraction:
- Only IV antibiotic(s) administered within 3 hours after the Severe Sepsis Presentation Time are acceptable.
  EXCEPTION: If there is documentation indicating IV access could not be established, antibiotics administered via intramuscular (IM) or intraosseous (IO) started within 3 hours after the Severe Sepsis Presentation Time are acceptable to select Value “1.”
- Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration within the appropriate time frame.
- 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.
  o Determine the class the administered antibiotics belong to, based on the class name in the shaded row above the antibiotic names.
  o 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.
  o 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.”
  o Review the chart to see that both drugs were started within 3 hours of severe sepsis presentation and if so, choose Value “1.”
  o If both drugs were not started within 3 hours, choose Value “2.”
Example:
Severe Sepsis Presentation Time 1200
Ciprofloxacin initiated at 1230
Vancomycin initiated at 1330
Combination Antibiotic Therapy Table:
  Ciprofloxacin is in column A
  Vancomycin is in column B
Both antibiotics were initiated within 3 hours of the Severe Sepsis Presentation Time, therefore value “1” should be selected.

<table>
<thead>
<tr>
<th>Combination Antibiotic Therapy Table</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Column A</strong></td>
</tr>
<tr>
<td>Aminoglycosides</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>Aztreonam OR</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

- If IV antibiotic(s) from Table 5.0 or an appropriate combination of IV antibiotics from Table 5.1 are not started within the 3 hours following presentation of severe sepsis, and the following conditions are met, choose value "1."
  - There is Physician/APN/PA documentation referencing the results of a culture from within 5 days prior to the antibiotic start time. The documentation must:
    - Identify the date of the culture results (must be within 5 days prior to the antibiotic start time).
    - Identify the suspected causative organism from the culture result and its antibiotic susceptibility.
  - The IV antibiotic(s) identified as appropriate per the physician/APN/PA documentation is started within 3 hours following the presentation of severe sepsis.

Examples:
  - Acceptable physician/APN/PA documentation: “Urine culture results from 9/10/17 show enterococcus, sensitive to vancomycin.”
  - The patient has severe sepsis with criteria met on 9/15/17 at 15:00 and the only antibiotic started is IV vancomycin at 15:30.

- If the patient has C. difficile, and IV antibiotic(s) from Table 5.0 or an appropriate combination of IV antibiotics from Table 5.1 are not started within the 3 hours following presentation of severe sepsis, and the following conditions are met, choose value "1."
  - There is physician/APN/PA documentation within 24 hours prior to the antibiotic start time identifying the presence of C. difficile.
  - Any one of the treatments below is initiated within 3 hours following severe sepsis presentation:
    - Oral vancomycin with or without oral or IV metronidazole (Flagyl)
    - Rectal vancomycin with or without IV metronidazole (Flagyl)
    - IV metronidazole (Flagyl) monotherapy
**Suggested Data Sources:**
- Anesthesia record
- Entire Emergency Department record
- ICU flow sheet
- IV flow sheet
- Medication administration record
- Nurses notes
- Operating room record
- PACU/recovery room record
- Perfusion record
- Physician/APN/PA progress notes

**Inclusion Guidelines for Abstraction:**
- Intravenous:
  - Antibiotic administered via intravenous route
  - Intramuscular or IM
  - Intraosseous or IO
  - Intravenous
  - IV bolus
  - IV infusion

**Exclusion Guidelines for Abstraction:**
- Give antibiotic stat
- Hang antibiotic
- Order for xx antibiotic
Data Element Name: Broad Spectrum or Other Antibiotic Administration Time

Collected For CMS: SEP-1

Definition: The earliest time at which an antibiotic was started in the time window of 24 hours preceding or 3 hours after Severe Sepsis Presentation Date and Time.

Suggested Data Collection Question: 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 Date and Time?

Format:
- Length: 5 – HH:MM (with or without colon) or UTD
- Type: Time
- Occurs: 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight – 00:00
- Noon – 12:00
- 5:31 am – 05:31
- 5:31 pm – 17:31
- 11:59 am – 11:59
- 11:59 pm – 23:59

Notes for Abstraction:
- 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>First dose of A</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>C</td>
<td>C</td>
<td>Antibiotic B</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>A</td>
<td>A</td>
<td>First dose of A</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>B</td>
<td>B</td>
<td>First dose of A</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>D</td>
<td>C</td>
<td>First dose of C</td>
<td></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.

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>L</td>
<td>Antibiotic L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>K</td>
<td>A</td>
<td>Dose of K in 3 hr. period</td>
<td></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>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>L</td>
<td>First dose of E</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>A</td>
<td>B</td>
<td>First dose of A</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>A</td>
<td>B</td>
<td>First dose of M</td>
<td></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:
  o A physician order for IV antibiotics is not sufficient unless the antibiotic ordered was marked as “started” with date/time noted.
  o 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 time frame.

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.

Suggested Data Sources:
• Anesthesia record
• Entire Emergency Department record
• ICU flow sheet
• IV flow sheet
• Medication administration record
• Nurses notes
• Operating room record
• PACU/recovery room record
• Perfusion record
• Physician/APN/PA notes
• Pre-arrival documentation that is part of the medical record

**Inclusion Guidelines for Abstraction:**
• Antibiotic administered via intravenous route
• Intramuscular or IM
• Intraosseous or IO
• Intravenous
• IV Bolus
• IV infusion

**Exclusion Guidelines for Abstraction:**
• Give antibiotic stat
• Hang antibiotic
• Order for xx antibiotic
Data Element Name: Clinical Trial

Collected For The Joint Commission Only: VTE-6; Collected for CMS Only: SEP-1

Definition: Documentation that during this hospital stay the patient was 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).

Suggested Data Collection Question: 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)?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) There is documentation that during this hospital stay the patient was 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).
- N (No) There is no documentation that during this hospital stay the patient was 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), or unable to determine from medical record documentation.

Notes for Abstraction:
- To select “Yes” to this data element, BOTH of the following must be true:
  1. **There must be a signed consent form for clinical trial.** For the purposes of abstraction, a clinical trial is defined as an experimental study in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized.
  2. **There must be documentation on the signed consent form that during this hospital stay the patient was 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).** Patients may either be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.
- In the following situations, select “No”:
1. **There is a signed patient consent form for an observational study only.** Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data is collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups.

2. **It is not clear whether the study described in the signed patient consent form is experimental or observational.**

3. **It is not clear which study population the clinical trial is enrolling.** Assumptions should not be made if it is not specified.

**VTE:**
Only capture patients enrolled in clinical trials studying patients with VTE (prevention or treatment interventions).

**SEP-1:**
Only capture patients enrolled in clinical trials studying patients with sepsis, severe sepsis or septic shock (treatment and interventions).

**Suggested Data Sources:**
**ONLY ACCEPTABLE SOURCES**
Signed consent form for clinical trial

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Comfort Measures Only

Collected For The Joint Commission Only: All SUB Measures, All TOB Measures, VTE-6

Definition: 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).

Suggested Data Collection Question: When is the earliest physician/APN/PA documentation of comfort measures only?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1. **Day 0 or 1**: The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).
2. **Day 2 or after**: The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).
3. **Timing unclear**: There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.
4. **Not Documented/UTD**: There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

Notes for Abstraction:
- Only accept terms identified in the list of inclusions. No other terminology will be accepted.
- Physician/APN/PA documentation of comfort measures only (hospice, comfort care, etc.) mentioned in the following contexts suffices:
  o Comfort measures only recommendation
  o Order for consultation or evaluation by a hospice care service
  o Patient or family request for comfort measures only
  o Plan for comfort measures only
  o Referral to hospice care service
  o Discussion of comfort measures
- Determine the earliest day comfort measures only (CMO) was DOCUMENTED by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select Value “1," “2," or “3" accordingly.
Example:
“Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.”

• State-authorized portable orders (SAPOs):
  o SAPOs are specialized forms or identifiers authorized by state law that translate a patient’s preferences about specific end-of-life treatment decisions into portable medical orders.
    Examples:
    ▪ DNR-Comfort Care form
    ▪ MOLST (Medical Orders for Life-Sustaining Treatment)
    ▪ POLST (Physician Orders for Life-Sustaining Treatment)
    ▪ Out-of-Hospital DNR (OOH DNR)
  o If there is a SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked, select Value “1.”
  o If a SAPO lists different options for CMO and any CMO option is checked, select Value “1,” “2,” or “3” as applicable.
  o If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.
  o 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 or the day after arrival that the patient does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.
    Example:
    Patient has a POLST dated prior to arrival in his chart and ED physician states in current record “Patient is refusing comfort measures, wants to receive full treatment and be a full code.”

• Documentation of an inclusion term in the following situations should be disregarded. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the ONLY documentation found is an inclusion term in the following situations, select Value “4.”
  o Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.
    Examples:
    ▪ Comfort measures only order in previous hospitalization record.
    ▪ “Pt. on hospice at home” in MD ED note.
  o Inclusion term clearly described as negative or conditional.
    Examples:
    ▪ “No comfort care"
    ▪ "Not appropriate for hospice care"
    ▪ “Comfort care would also be reasonable - defer decision for now”
    ▪ “DNRCCA” (Do Not Resuscitate – Comfort Care Arrest)
    ▪ “Family requests comfort measures only should the patient arrest.”
Documentation of “CMO” should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” – Cardiomyopathy context).

- If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select Value “1,” “2,” or “3” for this data element.

**Examples:**

- Physician documents in progress note on day 1 “The patient has refused Comfort Measures” AND then on day 2 the physician writes an order for a Hospice referral. Select Value “2.”
- ED physician documents in a note on day of arrival “Patient states they want to be enrolled in Hospice” AND then on day 2 there is a physician progress note with documentation of “Patient is not a Hospice candidate.” Select Value “1.”

**Suggested Data Sources:**

**PHYSICIAN/APN/PA DOCUMENTATION ONLY**

- Consultation notes
- Discharge summary
- DNR/MOLST/POLST forms
- Emergency Department record
- History and physical
- Physician orders
- Progress notes

**Excluded Data Sources:**

Restraint order sheet

**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

**Exclusion Guidelines for Abstraction:**

None
Data Element Name: Crystalloid Fluid Administration

Collected For CMS: SEP-1

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

Suggested Data Collection Question: Were crystalloid fluids initiated within the specified time frame AND completely infused based on the target ordered volume?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1 (Yes) Target volume of crystalloid fluids were ordered AND initiated within the specified time frame. Additionally, the target ordered volume was completely infused.

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

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

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

Notes for Abstraction:
- The specified time frame for abstraction of crystalloid fluids is within 6 hours prior through 3 hours after either of the following trigger events. If both are present the specified time frame is determined by the earliest trigger.
  - Initial Hypotension Date and Time
  - Septic Shock Presentation Date and Time
- The target ordered volume must be ordered and initiated within the specified time frame if Initial Hypotension or Septic Shock is present. Additionally, in order to choose Value “1,” the target ordered volume must be documented as completely infused. The target ordered volume is NOT required to be completely infused within the specified time frame. If the target ordered volume is not completely infused, choose Value “2.”
- Crystalloid fluid volumes ordered that are equivalent to 30 mL/kg or within 10% less than 30 mL/kg are considered the target ordered volume.
Example:
2000 mL of normal saline was ordered and initiated in the ED. The patient’s weight is not available or documented at the time of the order. After admission to critical care a weight is obtained of 74 kg. Based on this weight 30 mL/kg is 2220 mL. The 2000 mL ordered is within 10% lower of 2220 mL (2220 mL – 222 mL = 1998 mL) and is an acceptable volume.

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

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

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

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

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

- If the total volume of crystalloid fluids ordered is less than the target ordered volume, select Value “2.”
- If there is documentation the infusion was stopped prior to reaching the target ordered volume, select Value “2.”

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

- Crystalloid fluid orders:
  - Physician/APN/PA orders are required for the fluids.
The order must include the type of fluid, the volume of fluid, and a rate or time over which the fluids are to be given.

The terms bolus, wide-open, or open are acceptable for a rate or infusion duration.

If the type of fluid, volume of fluid, rate or infusion duration is missing, do not use the order toward the target ordered volume.

The target ordered volume may be in a single order or a series of multiple orders.

If crystalloid fluids are initiated via multiple physician/APN/PA orders, only abstract crystalloid fluids initiated within the specified time frame.

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

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

To determine if the target ordered volume was completely infused, one of the following must be documented along with the infusion start time. If one of the following is not documented, do not use the fluids toward the target ordered volume:

- An infusion rate
- Infusion duration or time over which to infuse
- Infusion end or completion time

**Examples:**
- Order for 1500 mL (30 mL/kg) of normal saline over 1 hour started at 08:00. There is no infusion end time documented, and no documentation indicating the 1500 mL was not infused. The infusion end time can be determined based on the duration in the order. Select Value “1.”
- Order for 1000 mL (30 mL/kg) normal saline bolus started at 09:30. The nurse documented an infusion rate of 1000 mL/hour. There is no fluid bolus end time documented, and no documentation indicating the 1000 mL was not infused. The infusion end time can be determined based on the rate. Select Value “1.”
- Order for 2000 mL (30 mL/kg) normal saline bolus started at 08:30. There is no infusion rate documented and no fluid bolus end time documented. An infusion end time cannot be determined. Choose Value “2.”

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

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

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

**Suggested Data Sources:**
- Ambulance or transport vehicle records
- Entire ED record
- Input and Output (I&O) flowsheet
- IV therapy record
- Medication Administration Record
- Patient weight record
- Physician/APN/PA orders

**Inclusion Guidelines for Abstraction:**
- 0.9% saline solution
- 0.9% Sodium Chloride Solution
- Isolyte
- Lactated Ringers Solution
- normal saline
- Normosol
- PlasmaLyte

**Exclusion Guidelines for Abstraction:**
Crystalloid solutions that are given to flush other medications or IV lines
Data Element Name: Crystalloid Fluid Administration Date

Collected For CMS: SEP-1

Definition: The earliest date on which crystalloid fluids were initiated within the specified time frame.

Suggested Data Collection Question: What was the earliest date on which crystalloid fluids were initiated within the specified time frame?

Format:
- Length: 10 – MM-DD-YYYY (includes dashes) or UTD
- Type: Date
- Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

Notes for Abstraction:

- 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.
- The specified time frame for abstraction of crystalloid fluids is within 6 hours prior through 3 hours after either of the following trigger events. If both are present the specified time frame is determined by the earliest trigger:
  - Initial Hypotension Date and Time
  - Septic Shock Presentation Date and Time
- 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.
- 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.
**Suggested Data Sources:**
- Ambulance or transport vehicle records
- Entire ED record
- IV therapy records or flow sheet
- Medication Administration Record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: *Crystalloid Fluid Administration Time*

Collected For CMS: SEP-1

**Definition:** The earliest time at which crystalloid fluids were initiated within the specified time frame.

**Suggested Data Collection Question:** What was the earliest time at which crystalloid fluids were initiated within the specified time frame?

**Format:**
- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

**Allowable Values:**
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

**Examples:**
- Midnight – 00:00  
  Noon – 12:00
- 5:31 am – 05:31  
  5:31 pm – 17:31
- 11:59 am – 11:59  
  11:59 pm – 23:59

**Notes for Abstraction:**
- 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.
- The specified time frame for abstraction of crystalloid fluids is within 6 hours prior through 3 hours after either of the following trigger events. If both are present the specified time frame is determined by the earliest trigger:
  - Initial Hypotension Date and Time
  - Septic Shock Presentation Date and Time
- 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.
• 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.

**Suggested Data Sources:**
- Ambulance or transport vehicle records
- Entire ED record
- IV therapy records or flow sheet
- Medication Administration Record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Decision to Admit Date

Collected For CMS/The Joint Commission: ED-2

Definition: The documented date the decision to admit to observation or inpatient status occurred. Decision to admit to observation or inpatient status date is the date the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital for continued care in the facility.

Suggested Data Collection Question: What was the earliest documented month, day, and year of the decision to admit?

Format:
Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:
Enter the documented date of the decision to admit
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

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

Examples:
o Documentation indicates the Decision to Admit Date was 03-42-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the Decision to Admit Date is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”
o Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the Decision to Admit Date was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the Decision to Admit Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select “UTD.”
**Note:** Transmission of a case with an invalid date as described above will be rejected from the CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for **Decision to Admit Date** allows the case to be accepted into the warehouse.

- When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports or ECGs) obtained prior to arrival. The intent is to utilize any documentation that reflects processes that occurred in the ED or hospital.
- For purposes of this data element, the source “Emergency Department record” includes any documentation from the time of ED arrival to the time the patient physically departed from the ED.
  
  **Example:**
  The ED departure is at 11:00 on 03-12-20XX. The attending physicians admit orders written in the inpatient record at 10:00 on 03-12-20XX are considered part of the ED record.

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

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

- **Decision to Admit Date** includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery.
  
  **Example:**
  The ED physician documents that he/she is sending the patient to the OR for surgery. The decision to admit to observation or inpatient status date will abstract as the date this was documented.

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

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

Examples:
  o Decision to Admit
  o Dispo
  o Disposition set to admit

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

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

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

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

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

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES
Emergency Department record

Inclusion Guidelines for Abstraction:
• Admit Order Date
• Disposition Date

Exclusion Guidelines for Abstraction:
• Bed assignment Date
• Direct admit patients seen in the ED
Data Element Name: Decision to Admit Time

Collected For CMS/The Joint Commission: ED-2

Definition: The documented time (military time) the decision to admit to observation or inpatient status occurred. Decision to admit to observation or inpatient status time is the time the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital for continued care in the facility.

Suggested Data Collection Question: What was the earliest documented time of the decision to admit?

Format:
- Length: 5 – HH:MM (with or without colon) or UTD
- Type: Time
- Occurs: 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight - 00:00
- Noon - 12:00
- 5:31 am - 05:31
- 5:31 pm - 17:31
- 11:59 am - 11:59
- 11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Decision to Admit Date should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change the Decision to Admit Date.

Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:
- For times that include “seconds,” remove the seconds and record the military time.
  Example: 15:00:35 would be recorded as 15:00.
- If the time of the decision to admit to observation or inpatient status is unable to be determined from medical record documentation, select “UTD.”
• The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”

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

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

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

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

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

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

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

  **Examples** that reflect a decision to admit was made:
  o ED physician note states “Discussed case with hospitalist on call, plan to admit.” The note references a discussion with another physician with “plan to admit” documented, indicating a decision to admit has been made.
ED physician note states “Discussed case with Dr. Brown who will admit patient to ICU.” The note references a discussion with another physician with “who will admit patient” documented, indicating a decision to admit has been made.

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

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

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

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

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

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

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

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

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

- If documentation of the decision to admit to observation or inpatient status time is prior to arrival or after departure from the ED, select, “UTD.”
Example:
The APN saw the patient in the clinic and sent him/her to the ED for admission. Select UTD.

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

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

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES
Emergency Department record

Inclusion Guidelines for Abstraction:
- Admit Order Time
- Disposition Time

Exclusion Guidelines for Abstraction:
- Bed assignment time
- Direct admit patients seen in the ED
- Report Called Time
Data Element Name: *Directive for Comfort Care or Palliative Care, Septic Shock*

Collected For CMS: SEP-1

**Definition:** Directive for Comfort Care 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. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Palliative Care is the identification, prevention, and treatment of suffering by means of assessment of the physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient’s quality of life. Palliative care ensures a partnership between practitioner, patient, and family to provide support in decision making at any stage in the patient’s care.

**Suggested Data Collection Question:** Did physician/APN/PA documentation of comfort measures only or palliative care occur?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
1 (Yes)  Physician/APN/PA documentation of comfort measures only or palliative care was prior to or within 6 hours of the presentation of septic shock.

2 (No)  Physician/APN/PA documentation of comfort measures only or palliative care was not prior to or within 6 hours of presentation of septic shock, or not documented or time is unclear.

**Notes for Abstraction:**
- Only accept terms identified in the list of inclusions. No other terminology will be accepted.
- 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
- State-authorized portable orders (SAPOs):
  - SAPOs are specialized forms or identifiers authorized by state law that translate a patient’s preferences about specific end-of-life treatment decisions into portable medical orders.
Examples:
- DNR-Comfort Care form
- MOLST (Medical Orders for Life-Sustaining Treatment)
- POLST (Physician Orders for Life-Sustaining Treatment)
- Out-of-Hospital DNR (OOH DNR)
  - If there is a SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked, select Value “1.”
  - If a SAPO lists different options for CMO and any CMO option is checked, select Value “1.”
  - If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.
  - 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.

Example:
Patient has a POLST dated prior to arrival in his chart and ED physician states in current record “Patient is refusing comfort measures, wants to receive full treatment and be a full code.”

- Documentation of an inclusion term in the following situations should be disregarded. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the ONLY documentation found is an inclusion term in the following situations, select Value “2.”
  - Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.
    - Examples:
      - Comfort measures only or palliative care order in previous hospitalization record.
      - “Pt. on hospice at home” in MD ED note.
  - Inclusion term clearly described as negative or conditional.
    - Examples:
      - “No comfort care"
      - "Not appropriate for hospice care"
      - “Comfort care would also be reasonable - defer decision for now”
      - “DNRCCA” (Do Not Resuscitate – Comfort Care Arrest)
      - “Family requests comfort measures only should the patient arrest.”
  - Documentation of “CMO” should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” – Cardiomyopathy context).
• If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only or Palliative Care, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO or Palliative Care, the source that indicates the patient is CMO or Palliative Care would be used to select Value “1.”

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY
• Consultation notes
• Discharge summary
• DNR/MOLST/POLST forms
• Emergency Department record
• History and physical
• Physician orders
• Progress notes

Excluded Data Sources:
Restraint order sheet

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
• Palliative Care
• Palliative Consult
• Terminal care
• Terminal extubation
• Withdraw care
• Withhold care

Exclusion Guidelines for Abstraction:
None
Data Element Name: Directive for Comfort Care or Palliative Care, Severe Sepsis

Collected For CMS: SEP-1

Definition: Directive for Comfort Care 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. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Palliative Care is the identification, prevention, and treatment of suffering by means of assessment of the physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient’s quality of life. Palliative care ensures a partnership between practitioner, patient, and family to provide support in decision making at any stage in the patient’s care.

Suggested Data Collection Question: Did physician/APN/PA documentation of comfort measures only or palliative care occur?

Format:
  
  Length: 1
  Type: Alphanumeric
  Occurs: 1

Allowable Values:

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.

Notes for Abstraction:

- Only accept terms identified in the list of inclusions. No other terminology will be accepted.
- 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
- State-authorized portable orders (SAPOs):
  - SAPOs are specialized forms or identifiers authorized by state law that translate a patient’s preferences about specific end-of-life treatment decisions into portable medical orders.
Examples:
- DNR-Comfort Care form
- MOLST (Medical Orders for Life-Sustaining Treatment)
- POLST (Physician Orders for Life-Sustaining Treatment)
- Out-of-Hospital DNR (OOH DNR)
  o If there is a SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked, select Value “1.”
  o If a SAPO lists different options for CMO and any CMO option is checked, select Value “1.”
  o If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.
  o 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.

Example:
Patient has a POLST dated prior to arrival in his chart and ED physician states in current record “Patient is refusing comfort measures, wants to receive full treatment and be a full code.”

- Documentation of an inclusion term in the following situations should be disregarded. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the ONLY documentation found is an inclusion term in the following situations, select Value “2.”
  o Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.

Examples:
- Comfort measures only or palliative care order in previous hospitalization record.
- “Pt. on hospice at home” in MD ED note.
  o Inclusion term clearly described as negative or conditional.

Examples:
- “No comfort care"
- "Not appropriate for hospice care"
- “Comfort care would also be reasonable - defer decision for now”
- “DNRCCA” (Do Not Resuscitate – Comfort Care Arrest)
- “Family requests comfort measures only should the patient arrest.”
  o Documentation of “CMO” should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” – Cardiomyopathy context).
• If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only or Palliative Care, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO or Palliative Care, the source that indicates the patient is CMO or Palliative Care would be used, select Value “1.”

**Suggested Data Sources:**
**PHYSICIAN/APN/PA DOCUMENTATION ONLY**
- Consultation notes
- Discharge summary
- DNR/MOLST/POLST forms
- Emergency Department record
- History and physical
- Physician orders
- Progress notes

**Excluded Data Sources:**
Restraint order sheet

**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
- Palliative Care
- Palliative Consult
- Terminal care
- Terminal extubation
- Withdraw care
- Withhold care

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: *Discharge Date*

Collected For CMS/The Joint Commission: All Records

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

Format:
- **Length:** 10 – MM-DD-YYYY (includes dashes)
- **Type:** Date
- **Occurs:** 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)

**Note:** The CMS Clinical Warehouse only allows data containing dates applicable to a specified quarter of data transmission. Data submitted for discharge quarters outside of the current submission deadline will be rejected.

Refer to the Data Transmission section of this manual for further guidance related to data transmission.

Notes for Abstraction:
Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

Suggested Data Sources:
- Discharge summary
- Face sheet
- Nursing discharge notes
- Physician orders
- Progress notes
- Transfer note
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
**Data Element Name:** Discharge Disposition

**Collected For The Joint Commission Only:** IMM-2, SUB-3, TOB-3; **CMS Only:** SEP-1

**Definition:** The final place or setting to which the patient was discharged on the day of discharge.

**Suggested Data Collection Question:** What was the patient’s discharge disposition on the day of discharge?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
1. Home
2. Hospice - Home
3. Hospice – Health Care Facility
4. Acute Care Facility
5. Other Health Care Facility
6. Expired
7. Left Against Medical Advice/AMA
8. Not Documented or Unable to Determine (UTD)

**Notes for Abstraction:**
- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.

  **Example:**
  Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select Value “5” (Other Health Care Facility).

- The medical record must be abstracted as documented (taken at “face value”). Inferences should not be made based on internal knowledge.

- If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.

  **Examples:**
  - Discharge summary dictated 2 days after discharge states patient went “home.” Physician note on day of discharge further clarifies that the patient will be going “home with hospice.” Select Value “2” (“Hospice - Home”).
  - Discharge planner note from day before discharge states “XYZ Nursing Home.” Discharge order from day of discharge states
“Discharge home.” Contradictory documentation, use latest. Select Value “1” (“Home”).

- Physician order on discharge states “Discharge to ALF.” Discharge instruction sheet completed after the physician order states patient discharged to “SNF.” Contradictory documentation, use latest. Select Value “5” (“Other Health Care Facility”).

- If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.
  - Acute Care Facility
  - Hospice – Health Care Facility
  - Hospice – Home
  - Other Health Care Facility
  - Home

- Hospice (Values “2” and “3”) includes discharges with hospice referrals and evaluations.

- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select Value “4” (“Acute Care Facility”).

- If the medical record states the patient is being discharged to assisted living care or an assisted living facility (ALF) and the documentation also includes nursing home, intermediate care or skilled nursing facility, select Value “1” (“Home”).

- If the medical record states the patient is being discharged to nursing home, intermediate care or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value “5” (“Other Health Care Facility”).

- If the medical record identifies the facility the patient is being discharged to by name only (e.g., “Park Meadows”), and does not reflect the type of facility or level of care, select Value “5” (“Other Health Care Facility”).

- If the medical record states only that the patient is being “discharged” and does not address the place or setting to which the patient was discharged, select Value “1” (“Home”).

- When determining whether to select Value “7” (“Left Against Medical Advice/AMA”):
  - Explicit “left against medical advice” documentation is not required. E.g., “Patient is refusing to stay for continued care” – Select Value “7.”
  - Documentation suggesting that the patient left before discharge instructions could be given does not count.
  - A signed AMA form is not required, for the purposes of this data element.
  - Do not consider AMA documentation and other disposition documentation as “contradictory.” If any source states the patient left against medical advice, select Value “7,” regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states “Discharged home with belongings” – Select “7.”

**Suggested Data Sources:**
- Discharge instruction sheet
- Discharge planning notes
- Discharge summary

Specifications Manual for National Hospital Inpatient Quality Measures
Discharges 01-01-19 (1Q19) through 06-30-19 (2Q19) 1-80
• Nursing discharge notes
• Physician orders
• Progress notes
• Social service notes
• Transfer record

Excluded Data Sources:
• Any documentation prior to the last two days of hospitalization
• Coding documents
• UB-04

Inclusion Guidelines for Abstraction:
Home (Value 1):
• Assisted Living Facilities (ALFs) – Includes ALFs and assisted living care at: nursing home, intermediate care, and skilled nursing facilities
• Court/Law Enforcement – includes detention facilities, jails, and prison
• Home – includes board and care, foster or personal care homes, retirement communities, and homeless shelters
• Home with Home Health Services
• Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization

Hospice – Home (Value 2):
Hospice in the home (or other “Home” setting as above in Value 1)

Hospice – Health Care Facility (Value 3):
• Hospice - General Inpatient and Respite
• Hospice - Residential and Skilled Facilities
• Hospice - Other Health Care Facilities

Acute Care Facility (Value 4):
• Acute Short Term General and Critical Access Hospitals
• Cancer and Children’s Hospitals
• Department of Defense and Veteran’s Administration Hospitals

Other Health Care Facility (Value 5):
• Extended or Intermediate Care Facility (ECF/ICF)
• Long Term Acute Care Hospital (LTACH)
• Nursing Home or Facility including Veteran’s Administration Nursing Facility
• Psychiatric Hospital or Psychiatric Unit of a Hospital
• Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
• Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
• Transitional Care Unit (TCU)
• Veterans Home

Exclusion Guidelines for Abstraction:
None
Data Element Name: Discharge Time

Collected For CMS: SEP-1

Definition: The time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.

Suggested Data Collection Question: What time was the patient discharged?

Format:
- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight – 00:00
- Noon – 12:00
- 5:31 am – 05:31
- 5:31 pm – 17:31
- 11:59 am – 11:59
- 11:59 pm – 23:59

Notes for Abstraction:
- Abstract the earliest documented time of the following:
  - Discharge from acute inpatient care
  - Left against medical advice (AMA)
  - Expired
- If the time the patient was discharged from acute inpatient care, left AMA, or expired is unable to be determined from medical record documentation, enter “UTD.”
- 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.”
- If the patient expired and there are multiple times, such as a time the patient was pronounced in physician notes and an administrative time the patient was discharged, use the time the patient was pronounced.
• If the patient expired and there is not a pronounced time but there is a discharge
time, use the discharge time.
• If the patient was discharged from acute inpatient care, left AMA, or transferred out
to another facility, use the time the patient actually left, not the time the order was
written.
• If there are multiple times documented when the patient was discharged from
acute inpatient care or left AMA, use the earliest time.

**Suggested Data Sources:**
- Death certificate
- Discharge summary
- Nurses Notes
- Progress Notes
- Resuscitation records

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: ED Departure Date

Collected For CMS/The Joint Commission: ED-2; Collected For The Joint Commission Only: ED-1

Definition: The month, day, and year at which the patient departed from the emergency department.

Suggested Data Collection Question: What is the date the patient departed from the emergency department?

Format:
- Length: 10 – MM-DD-YYYY (includes dashes) or UTD
- Type: Date
- Occurs: 1

Allowable Values:
Enter the documented date of the ED Departure
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:
- The medical record must be abstracted as documented (taken at “face value”).
  When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the Discharge Date]) and no other documentation is found that provides this information, the abstractor should select “UTD.”

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

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

- If the date the patient departed is unable to be determined from medical record documentation, select “UTD.”
• If the date of departure is not documented, but the date can be determined from other documentation in the ED record, this is acceptable to use (the patient arrived and was transferred on the same day).

• Data fields representing ED Departure Date in electronic documentation for this specific episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge date being abstracted.

  **Examples:**
  o Patient departed
  o Patient transferred off the floor (OTF)
  o Check out time
  o Transported to

• For patients who are placed into observation outside the services of the emergency department, abstract the date of departure from the emergency department.

• For patients who are placed into observation under the services of the emergency department, abstract the date of departure from the observation services (e.g., patient is seen in the ED and admitted to an observation unit of the ED on 01-01-20xx then is discharged from the observation unit on 01-03-20xx abstract 01-03-20xx as the departure date).

• If there is a departure date listed within a disposition heading from the ED, this may be used for **ED Departure Date**.

• The inclusion list is not to be considered a comprehensive list of inclusions.

**Suggested Data Sources:**

**ONLY ACCEPTABLE SOURCES:**

Emergency Department record

**Inclusion Guidelines for Abstraction:**

• ED Checkout Date
• ED Departure Date
• ED Discharge Date
• ED Leave Date
• ED Transport Date

**Exclusion Guidelines for Abstraction:**

Patient Admission Date
Data Element Name: *ED Departure Time*

**Collected For CMS/The Joint Commission:** ED-2; **Collected For The Joint Commission Only:** ED-1

**Definition:** The time (military time) represented in hours and minutes at which the patient departed from the emergency department.

**Suggested Data Collection Question:** What is the time the patient departed from the emergency department?

**Format:**
- **Length:** 5 – HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

**Allowable Values:**
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

**Examples:**
- Midnight - 00:00
- Noon - 12:00
- 5:31 am - 05:31
- 5:31 pm - 17:31
- 11:59 am - 11:59
- 11:59 pm - 23:59

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *ED Departure Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change the *ED Departure Date*.

**Example:**
- Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

**Notes for Abstraction:**
- For times that include “seconds,” remove the seconds and record the military time.
  **Example:**
  - 15:00:35 would be recorded as 15:00.
- The intention is to capture the latest time at which the patient was receiving care in the emergency department.
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no
other documentation is found that provides this information, the abstractor should select “UTD.”

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

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

- ED Departure Time is the time the patient physically left the emergency department (e.g., nurse’s notes state “18:00 transfer to floor-room 300” and other documentation includes a time that the patient left the ED via stretcher, abstract the later time or nurses notes state “18:00 transport to unit” and other documentation includes a time that the patient actually left the ED to be transferred, abstract the later time).
- If the time the patient departed is unable to be determined from medical record documentation, select, “UTD.”
- When more than one acceptable emergency department departure/discharge time is documented, abstract the latest time.

**Example:**
Two departure times are found in the nurse’s notes: 12:03 via wheelchair and 12:20 via wheelchair. Select the later time of 12:20.

- Do not use documentation of vital signs or medications if they are later than the ED departure time.
- Do not use the time the discharge order was written because it may not represent the actual time of departure.
- Data fields representing *ED Departure Time* in electronic documentation for this specific episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge time being abstracted.

**Examples:**
- Patient departed
- Patient transferred off the floor (OTF)
- Check out time
- Transferred to

- If there is a departure time listed within a disposition heading from the ED, this may be used for *ED Departure Time*.
- For patients who are placed into observation outside the services of the emergency department, abstract the time of departure from the emergency department.
If the patient is placed into observation services and remains in the ED or in a unit of the ED abstract the time they depart the ED or ED unit for the floor/surgery etc. Do not abstract the time they are placed into observation services.

- For patients who are placed into observation under the services of the emergency department, abstract the time of departure from the observation services.
  - If a patient is seen in the ED and admitted to an observation unit of the ED, then discharged from the observation unit, abstract the time they depart the observation unit.
  - If the patient is placed into observation services and remains in the ED or in a unit of the ED abstract the time they depart the ED or ED unit for the floor/surgery etc. Do not abstract the time they are placed into observation services.
- If the documented ED Departure Time is prior to arrival, enter “UTD.”
- If the patient expired in the ED, use the time of death as the departure time.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

**Suggested Data Sources:**
**ONLY ACCEPTABLE SOURCES:**
Emergency Department record

**Inclusion Guidelines for Abstraction:**
- ED Check Out Time
- ED Departure Time
- ED Discharge Time
- ED Leave Time
- ED Transport Time

**Exclusion Guidelines for Abstraction:**
- Patient Admission Time
- Report Called Time
Data Element Name: *ED Patient*

**Collected For CMS/The Joint Commission:** ED-2  
**Collected For The Joint Commission Only:** ED-1

**Definition:** Patient received care in a dedicated emergency department of the facility.

**Suggested Data Collection Question:** Was the patient an ED patient at the facility?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **Y** (Yes) There is documentation the patient was an ED patient.
- **N** (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

**Notes for Abstraction:**
- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes.”

**ED:**
- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No.” This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No,” even if the transferred patient is seen in this facility’s ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No.” This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No” even if the transferred patient is seen in this facility’s ED.
Suggested Data Sources:
- Emergency Department record
- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
- Fast Track ED
- Terms synonymous with Urgent Care
- Urgent Care
Data Element Name: *First Name*

Collected For CMS Only: All Records (Optional Element)

Definition: The patient’s first name.

Suggested Data Collection Question: What is the patient’s first name?

Format:
- **Length:** 30
- **Type:** Character
- **Occurs:** 1

Allowable Values:
Enter the patient’s first name. Up to 30 letters, numbers, and/or special characters can be entered.

**Note:** Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = \ ; ' . , / and space

Notes for Abstraction:
None

Suggested Data Sources:
- Emergency Department record
- Face sheet
- History and physical

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: *Hispanic Ethnicity*

Collected For CMS/The Joint Commission: All Records

Definition: Documentation that the patient is of Hispanic ethnicity or Latino.

Suggested Data Collection Question: Is the patient of Hispanic ethnicity or Latino?

Format:
- Length: 1
- Type: Character
- Occurs: 1

Allowable Values:
- Y (Yes) Patient is of Hispanic ethnicity or Latino.
- N (No) Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

Notes for Abstraction:
The data element, *Race*, is required in addition to this data element.

Suggested Data Sources:
- Emergency Department record
- Face sheet
- History and physical
- Nursing admission assessment
- Progress notes

Inclusion Guidelines for Abstraction:
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.”

Examples:
- Black-Hispanic
- Chicano
- H
- Hispanic
- Latin American
- Latino/Latina
- Mexican-American
- Spanish
- White-Hispanic

Exclusion Guidelines for Abstraction:
None
Data Element Name: *ICD-10-CM Other Diagnosis Codes*

Collected For CMS/The Joint Commission: All Records

Definition: The other or secondary ICD-10-CM codes associated with the diagnosis for this hospitalization.

Suggested Data Collection Question: What were the ICD-10-CM other diagnosis codes selected for this medical record?

Format:
- **Length:** 3-7 (without decimal point or dot)
- **Type:** Character (upper or lower case)
- **Occurs:** 24

Allowable Values:

Notes for Abstraction:
None

Suggested Data Sources:
- Discharge summary
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: ICD-10-PCS Other Procedure Codes

Collected For CMS/The Joint Commission: All Records

Definition: The other or secondary ICD-10-PCS codes identifying all significant procedures other than the principal procedure.

Suggested Data Collection Question: What were the ICD-10-PCS code(s) selected as other procedure(s) for this record?

Format:
- Length: 3-7 (without decimal point or dot)
- Type: Character (upper or lower case)
- Occurs: 24

Allowable Values:
Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles): https://www.cms.gov/Medicare/Coding/ICD10/index.html

Notes for Abstraction:
None

Suggested Data Sources:
• Discharge summary
• Face sheet
• UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
**Data Element Name:** *ICD-10-PCS Other Procedure Dates*

**Collected For CMS/The Joint Commission:** All Records

**Definition:** The month, day, and year when the associated procedure(s) was (were) performed.

**Suggested Data Collection Question:** What were the date(s) the other procedure(s) were performed?

**Format:**
- **Length:** 10 – MM-DD-YYYY (includes dashes) or UTD
- **Type:** Date
- **Occurs:** 24

**Allowable Values:**
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

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

**Examples:**
- Documentation indicates the *ICD-10-PCS Other Procedure Dates* was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the *ICD-10-PCS Other Procedure Dates* is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-20xx and documentation indicates the *ICD-10-PCS Other Procedure Dates* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-10-PCS Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters of care and the abstractor should select “UTD.”

**Note:** Transmission of a case with an invalid date as described above will be rejected from the CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *ICD-10-PCS Other Procedure Dates* allows the case to be accepted into the warehouse.
Suggested Data Sources:
- Consultation notes
- Diagnostic test reports
- Discharge summary
- Face sheet
- Operative notes
- Procedure notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: *ICD-10-CM Principal Diagnosis Code*

Collected For CMS/The Joint Commission: All Records

**Definition:** The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

**Suggested Data Collection Question:** What was the ICD-10-CM code selected as the principal diagnosis for this record?

**Format:**
- **Length:** 3-7 (without decimal point or dot)
- **Type:** Character (upper or lower case)
- **Occurs:** 1

**Allowable Values:**

**Notes for Abstraction:**
None

**Suggested Data Sources:**
- Discharge summary
- Face sheet
- UB-04

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: ICD-10-PCS Principal Procedure Code

Collected For CMS/The Joint Commission: All Records

Definition: The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Suggested Data Collection Question: What was the ICD-10-PCS code selected as the principal procedure for this record?

Format:
- Length: 3-7 (without decimal point or dot)
- Type: Character (upper or lower case)
- Occurs: 1

Allowable Values:
Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles): https://www.cms.gov/Medicare/Coding/ICD10/index.html

Notes for Abstraction:
None

Suggested Data Sources:
- Discharge summary
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: ICD-10-PCS Principal Procedure Date

Collected For CMS/The Joint Commission: All Records

Definition: The month, day, and year when the principal procedure was performed.

Suggested Data Collection Question: What was the date the principal procedure was performed?

Format:
- Length: 10 – MM-DD-YYYY (includes dashes) or UTD
- Type: Date
- Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

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

Examples:
- Documentation indicates the ICD-10-PCS Principal Procedure Date was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the ICD-10-PCS Principal Procedure Date is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-20xx and documentation indicates the ICD-10-PCS Principal Procedure Date was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the ICD-10-PCS Principal Procedure Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select “UTD.”

Note: Transmission of a case with an invalid date as described above will be rejected from the CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for ICD-10-PCS Principal Procedure Date allows the case to be accepted into the warehouse.
Suggested Data Sources:
• Consultation notes
• Diagnostic test reports
• Discharge summary
• Face sheet
• Operative notes
• Procedure notes
• Progress notes
• UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
**Data Element Name:** Influenza Vaccination Status

**Collected For The Joint Commission Only:** IMM-2

**Definition:** Documentation of the patient’s vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization. The main types of influenza vaccine available are: an attenuated (weakened) live vaccine given as a nasal spray and approved for healthy nonpregnant persons 2-49 years of age, a killed (inactivated) influenza vaccine administered via intramuscular (IM) needle injection for persons 6 months and older, an intradermal vaccine administered to persons 18-64 years old, or a recombinant vaccine administered IM to a person 18 years or older.

**Suggested Data Collection Question:** What is the patient’s influenza vaccination status?

**Format:**

- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**

1. Influenza vaccine was given during this hospitalization.
2. Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization.
3. Documentation of patient's or caregiver's refusal of influenza vaccine.
4. There was documentation of an allergy/sensitivity to influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs OR is not likely to be effective because of bone marrow transplant within the past 6 months OR history of Guillian-Barré syndrome within 6 weeks after a previous influenza vaccination.
5. None of the above/Not documented/Unable to determine from medical record documentation.
6. Only select this allowable value if there is documentation the vaccine has been ordered but has not yet been received by the hospital due to problems with vaccine production or distribution AND Allowable Values 1-5 are not selected.

**Notes for Abstraction:**

- Each year, flu vaccines start to become available usually in September and most influenza vaccine is administered in October – December, but the vaccine is recommended to be administered throughout the influenza season which can last until May in some years. For the purposes of this project, the hospitals are only responsible for discharges October through March.
Only influenza vaccines administered during August through March are acceptable.

- The caregiver is defined as the surrogate decision-maker, or healthcare surrogate and may be a patient’s family member or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who is responsible for the healthcare decision-making and care of the minor patient or the adult patient when that patient is unable to make this decision on his/her own.

- In order to select “Influenza vaccine was given during this hospitalization,” there must be documentation either on the MAR, nursing notes, standing orders, etc., where the vaccine was dated and signed as administered.

- In situations where there is documentation that would support more than one of the Allowable Values, 1-4, select the smallest number.
  
  **Example:**
  Nurses’ notes have documentation the patient refused. Vaccination order sheet has documentation that the patient was vaccinated during this hospitalization. You will select Value “1,” as it is the smallest number.

- If there is no documentation to support any of the Allowable Values 1-4, and there is physician/APN/PA documentation that they will administer the vaccine after discharge or physician/APN/PA documentation not to administer the vaccine for a reason other than those noted as acceptable in this data element, select Value “5.”

- If there is conflicting documentation regarding influenza vaccine refusal, select Value “5.”

  **Example:**
  There is documentation of refusal in the influenza immunization screening for the current admission and the patient did not receive the vaccine, but a subsequent narrative note states the patient wants to receive the vaccine, select Value “5.”

- If there is conflicting documentation regarding whether the influenza vaccine is current, use documentation reflecting it is current.

  **Examples:**
  - There is documentation in the medical record stating “influenza vaccination status: current,” but the physician H&P indicates the patient has not received an influenza vaccine this season, select Value “2.”
  - There is documentation in medical record stating “influenza vaccination status: current,” but the influenza vaccination date is from the previous season, select Value “2.”

- If there is conflicting documentation regarding administration of the vaccine in the hospital, use documentation reflecting the vaccine was given during the admission.

  **Example:**
  There is documentation in the medical record indicating the vaccine was given (dated and signed as administered) during the hospital stay, but the discharge summary states order for vaccine was cancelled and patient did not receive vaccine during the hospital stay, select Value “1.”

- If there is documentation that the patient received the vaccine and only the current year is documented, i.e., no month or day, select Value “2.”
Example:
There is documentation the patient received the vaccine in 2009 and it is October 2009, select Value “2.”

- If there is documentation the patient received the vaccine the year prior to the current year and the discharge is not January, February or March, select Value “5.”

  Examples:
  - There is documentation the patient received the vaccine in 2008 and it is October 2009, select Value “5.”
  - There is documentation the patient received the vaccine in 2008 and it is January 2009, select Value “2.”

- If it is documented in the chart that the patient’s influenza vaccination status is “up to date” or “current,” select Allowable Value “2.” Documentation of “up to date” or “current” in the vaccination record that does not reference the influenza vaccine is not sufficient to select Allowable Value “2.”

- Documentation of the acronym “UTD,” even with specific reference to the influenza vaccine, is not sufficient to select Allowable Value “2.”

- Documentation from a pre-admission screening or previous episode of care indicating that the patient received the influenza vaccine with a date from the current season would be acceptable to choose Value “2.”

- Documentation of influenza vaccine refusal from an admission or encounter that is prior to arrival cannot be used for selecting Value “3.” Information for selecting Value “3” must be assessed and documented within the current admission.

- Documentation of unavailability due to problems with vaccine production or distribution from an admission or encounter that is prior to arrival cannot be used for selecting Value “6.” Information for selecting Value “6” must be assessed and documented within the current admission.

Suggested Data Sources:
- Consultation notes
- Discharge summary
- Emergency Department record
- Immunization assessment forms
- Medication administration record
- Nursing admission assessment
- Nursing notes
- Physician orders
- Physician progress notes
- Social service notes
- Transfer forms
- Vaccine order sheet

Inclusion Guidelines for Abstraction:
All patients discharged during October, November, December, January, February, or March
Acceptable terms for influenza vaccines include those listed below or refer to CDC list of Influenza vaccines at http://www.cdc.gov/flu/protect/vaccine/vaccines.htm.
- Afluria
- Flu shot
- Flu vaccine
- FluLaval
- FluMist
- Fluarix
- Fluvirin
- Fluzone
- Fluzone High Dose
- Influenza virus vaccine
- Live attenuated influenza vaccine
- Quadrivalent influenza vaccine
- Trivalent influenza vaccine

**Exclusion Guidelines for Abstraction:**
- All discharges from April through September
- Pandemic monovalent vaccine, e.g. H1N1
- Patients with an organ transplant during the current hospitalization (Appendix A, Table 12.10)
Data Element Name: Initial Hypotension

Collected For CMS: SEP-1

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

Suggested Data Collection Question: Was initial hypotension present within the specified time frame?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

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

Notes for Abstraction:
- The specified time frame for assessing Initial Hypotension is 6 hours prior to or within 6 hours following Severe Sepsis Presentation Date and Time.
- The criteria for determining that Initial Hypotension was present are as follows:
  - Two hypotensive blood pressure readings from measurements taken at different times within the specified time frame. The hypotensive blood pressure readings do not need to be consecutive but need to be within 3 hours of each other. Acceptable readings are:
    - systolic blood pressures <90, or
    - mean arterial pressures (MAP) <65 or
    - a decrease in systolic blood pressure by >40 mm/Hg.
  - Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection or severe sepsis and not other causes.
- Use the time the hypotensive blood pressures were taken or obtained. If time taken or obtained is not available, use recorded or documented time. Do not abstract hypotensive values from narrative charting unless there is no other documentation that reflects the time that the same hypotensive values were obtained.
- Hypotensive BPs obtained within the operating room (OR) should not be used.
- Hypotensive BPs documented from an orthostatic BP evaluation should not be used.
- For the following, physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time is required.
If hypotension (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it **should not be used**. Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation.

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

**Example:**
"Hypotensive after pain meds"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Initial hypotension is hypotension that is present prior to the target ordered volume of crystalloid fluids being completely infused.
- If hypotension was present within 6 hours prior to or within 6 hours following Severe Sepsis Presentation Date and Time, select Value “1.”
- If hypotension was not present within 6 hours prior to or within 6 hours following Severe Sepsis Presentation Date and Time, select Value “2.”
- If within 24 hours of the Severe Sepsis Presentation Time there is physician/APN/PA or nursing documentation indicating a hypotensive reading is invalid, erroneous or questionable, disregard that reading when determining the presence of Initial Hypotension.
- If there is physician/APN/PA documentation indicating the patient does not have hypotension and it is referencing a specific time period in which there was one or more hypotensive values recorded, the hypotensive value(s) should not be used. The documentation must be within 24 hours following the low blood pressure value(s).

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

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

Suggested Data Sources:

- Entire ED record
- Nurses notes
- Physician/APN/PA notes
- Vital signs record or flow sheet

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None
Data Element Name: Initial Hypotension Date

Collected For CMS: SEP-1

Definition: The date of the documentation of initial hypotension in the 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.

Suggested Data Collection Question: On which date was initial hypotension present 6 hours prior to or within 6 hours following Severe Sepsis Presentation Date and Time?

Format:
   Length: 10 – MM-DD-YYYY (includes dashes) or UTD
   Type: Date
   Occurs: 1

Allowable Values:
   MM = Month (01-12)
   DD = Day (01-31)
   YYYY = Year (20xx)
   UTD = Unable to Determine

Notes for Abstraction:
   • Use the earliest date of the second hypotensive blood pressure documented within the time period of 6 hours prior to or within 6 hours following Severe Sepsis Presentation Date and Time (to determine the second hypotensive blood pressure, see the Initial Hypotension data element).
   • For patients with more than two hypotensive blood pressures in the time period of 6 hours prior to or within 6 hours following Severe Sepsis Presentation Date and Time, use the date of the second hypotensive blood pressure documented within the time period.
   • Use the date documented for when hypotensive blood pressure was taken or obtained. If date taken or obtained is not available, use recorded or documented date.

Suggested Data Sources:
   • Entire ED record
   • Nurses notes
   • Physician/APN/PA notes
   • Vital signs record or flow sheet

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None
Data Element Name: *Initial Hypotension Time*

Collected For CMS: SEP-1

Definition: The time of the documentation of initial hypotension in the 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.

Suggested Data Collection Question: At which time was initial hypotension present 6 hours prior to or within 6 hours following *Severe Sepsis Presentation Date and Time*?

Format:
- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format. With the exception of midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight – 00:00
- Noon – 12:00
- 5:31 am – 05:31
- 5:31 pm – 17:31
- 11:59 am – 11:59
- 11:59 pm – 23:59

Notes for Abstraction:
- Use the earliest time of the second hypotensive blood pressure documented within the time period of 6 hours prior to or within 6 hours following *Severe Sepsis Presentation Date and Time* (to determine the second hypotensive blood pressure, see the *Initial Hypotension* data element).
- For patients with more than two hypotensive blood pressures in the time period of 6 hours prior to or within 6 hours following *Severe Sepsis Presentation Date and Time*, use the time of the second hypotensive blood pressure documented within the time period.
- Use the time documented for when hypotensive blood pressure was taken or obtained. If time taken or obtained is not available, use recorded or documented time.
Suggested Data Sources:
- Entire ED record
- Nurses notes
- Physician/APN/PA notes
- Vital signs record or flow sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Initial Lactate Level Collection

Collected For CMS: SEP-1

Definition: Documentation of collection of an initial lactate level within the specified time frame.

Suggested Data Collection Question: Was an initial lactate level drawn within the specified time frame?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

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

Notes for Abstraction:
- The specified time frame within which an initial lactate must be drawn is within 6 hours prior through 3 hours following severe sepsis presentation.
  - If multiple lactate levels are drawn within the specified time frame, use the lactate drawn PRIOR to the Severe Sepsis Presentation Time with the HIGHEST level.
  - If multiple lactate levels are drawn ONLY in the 3 hours after the Severe Sepsis Presentation Time, use the lactate drawn with the HIGHEST level within this time frame.
- If there is more than one time of documentation for the Initial Lactate Level Collection, use the following order to determine which time to abstract.
  1. Laboratory documentation indicating date and time lactate was drawn.
  2. Date and Time the lactate is documented as drawn in a non-narrative location (e.g., sepsis flowsheet, checklist, screening).
  3. Narrative note indicating lactate is drawn with an associated date and time.
- If there is no documentation indicating a lactate was drawn or collected, but there is supportive documentation that a lactate was drawn, use the earliest supportive documentation (e.g., lactate sent to lab, lactate received, lactate result).
- If within 24 hours of the Severe Sepsis Presentation Time there is physician/APN/PA or nursing documentation that a lactate value is invalid, erroneous or questionable, disregard that value.
- Use documentation specifying a lactate was actually drawn or collected. Do not use documentation such as “Labs Drawn” as it is not specific for lactate level.
- Do not use a physician order for lactate levels as it does not specify that lactate level was drawn; however, you may use a physician order that has a notation “drawn” or “collected” next to it.
• If a lactate level is ordered and there is an attempt to collect it, but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, select Value “1.”
• If a lactate level is drawn but there are no results in the record, choose Value “1.”

Suggested Data Sources:
• Laboratory Reports
• Nursing Notes
• Physician/APN/PA notes or orders

Inclusion Guidelines for Abstraction:
• Lactate drawn
• Lactate level collected
• Lactic acid drawn

Exclusion Guidelines for Abstraction:
Labs drawn
Data Element Name: *Initial Lactate Level Date*

**Collected For CMS:** SEP-1

**Definition:** The date on which the initial lactate level was drawn.

**Suggested Data Collection Question:** What was the date on which the initial lactate level was drawn?

**Format:**
- **Length:** 10 – MM-DD-YYYY (includes dashes) or UTD
- **Type:** Date
- **Occurs:** 1

**Allowable Values:**
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

**Notes for Abstraction:**
- If there is more than one date of documentation for the *Initial Lactate Level Collection*, use the following order to determine which date to abstract.
  1. Laboratory documentation indicating date lactate was drawn.
  2. Non-narrative location indicating lactate was drawn with an associated date (e.g., sepsis flowsheet, checklist, screening).
  3. Narrative note indicating lactate is drawn with an associated date.
- If there is not a lactate draw or collected date documented, but there is supportive documentation that a lactate was drawn, use the date of the earliest supportive documentation (e.g., lactate sent to lab, lactate received date, lactate result date).
- Use documentation specifying the date a lactate was actually drawn or collected. Do not use documentation such as “Labs Drawn” as it is not specific for lactate level.
- Do not use a physician order for lactate levels as it does not specify that lactate level was drawn or reported, unless there is a notation of “drawn” or “collected” next to the order, including a date.
- If a lactate level is ordered and there is an attempt to collect it, but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, use the date of attempted lactate level collection.

**Suggested Data Sources:**
- Laboratory Reports
- Nursing Notes
- Physician/APN/PA notes or orders
Inclusion Guidelines for Abstraction:
• Lactate level collected
• Lactate level drawn
• Lactic acid drawn

Exclusion Guidelines for Abstraction:
Labs drawn
Data Element Name: Initial Lactate Level Result

Collected For CMS: SEP-1

Definition: Documentation of the initial lactate level result.

Suggested Data Collection Question: What was the initial lactate level result?

Format:
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

Allowable Values:
- **1 (<=2):** The initial lactate level was less than or equal to 2 mmol/L, or there is no result in the chart, or unable to determine the result.
- **2 (>2 and <4.0):** The initial lactate level was greater than 2 mmol/L and less than 4 mmol/L.
- **3 (>=4):** The initial lactate level was 4 mmol/L or more.

Notes for Abstraction:
- Lactate levels may be reported as mmol/L or mg/dL. Use the following to cross reference mmol/L and mg/dL equivalents.
  - 2 mmol/L is equivalent to 18 mg/dL
  - 4 mmol/L is equivalent to 36 mg/dL
- Use the result for the initial lactate level drawn in the data element Initial Lactate Level Collection.
- If there was an initial lactate level collected but there is no result, or the result cannot be determined, choose Value “1.”
- If point of care (POC) results and laboratory results are obtained from the same sample, use the results that are recorded first.
- 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.”

Suggested Data Sources:
- Laboratory results
- Physician/APN/PA notes

Inclusion Guidelines for Abstraction:
- Lactate results
- Lactic acid results

Exclusion Guidelines for Abstraction:
None
Data Element Name: Initial Lactate Level Time

Collected For CMS: SEP-1

Definition: The time at which the initial lactate level was drawn.

Suggested Data Collection Question: What was the time at which the initial lactate level was drawn?

Format:
   Length: 5 - HH:MM (with or without colon) or UTD
   Type: Time
   Occurs: 1

Allowable Values:
   HH = Hour (00-23)
   MM = Minutes (00-59)
   UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of midnight and Noon:
   • If the time is in the a.m., conversion is not required
   • If the time is in the p.m., add 12 to the clock time hour

Examples:
   Midnight – 00:00  Noon – 12:00
   5:31 am – 05:31  5:31 pm – 17:31
   11:59 am – 11:59 11:59 pm – 23:59

Notes for Abstraction:
• If there is more than one time of documentation for the Initial Lactate Level Collection, use the following order to determine which time to abstract.
   1. Laboratory documentation indicating time lactate was drawn.
   2. Non-narrative location indicating lactate was drawn with an associated time (e.g., sepsis flowsheet, checklist, screening).
   3. Narrative note indicating lactate is drawn with an associated time.
• If there is not a lactate draw or collected time documented, but there is supportive documentation that a lactate was drawn, use the time of the earliest supportive documentation (e.g., lactate sent to lab, lactate received time, lactate result time).
• Use documentation specifying the time a lactate was actually drawn or collected. Do not use documentation such as “Labs Drawn” as it is not specific for lactate level.
• Do not use a physician order for lactate levels as it does not specify that lactate level was drawn, unless there is a notation next to the lactate level order indicating it was drawn or collected, with a time noted.
• If a lactate level is ordered and there is an attempt to collect it, but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, use the time of attempted lactate level collection.
Suggested Data Sources:
- Laboratory Reports
- Nursing Notes
- Physician/APN/PA notes or orders

Inclusion Guidelines for Abstraction:
- Lactate level collected
- Lactate level drawn
- Lactic acid drawn

Exclusion Guidelines for Abstraction:
Labs drawn
**Data Element Name:** *Last Name*

**Collected For CMS Only:** All Records (Optional Element)

**Definition:** The patient’s last name.

**Suggested Data Collection Question:** What is the patient’s last name?

**Format:**
- **Length:** 60
- **Type:** Character
- **Occurs:** 1

**Allowable Values:**
Enter the patient’s last name. Up to 60 letters, numbers, and/or special characters can be entered.

**Note:** Only the following special characters will be allowed:

~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] ; ' . , / and space

**Notes for Abstraction:**
None

**Suggested Data Sources:**
- Emergency Department record
- Face sheet
- History and physical

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
**Data Element Name:** Measure Category Assignment

**Collected For The Joint Commission Only:** Used in calculation of The Joint Commission's aggregate data and in the transmission of the Hospital Clinical Data file

**Notes:**
- Episode of care records that calculate with a Measure Category Assignment of "X" (missing data) for one or more measures will be rejected by the CMS Clinical Warehouse and the Joint Commission's Data Warehouse. Refer to the Missing and Invalid data section in this manual for more information.
- All hospital measures use this data element. The ORYX® Vendor's calculated Measure Category Assignment will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in The Joint Commission’s data quality analysis and continuous measure verification process. ORYX Vendors can refer to The Joint Commission’s ORYX Data Quality Manual for more information.
- Measure Category Assignment must be transmitted to The Joint Commission but cannot be transmitted to CMS. Files transmitted to the CMS Clinical Warehouse that contain Measure Category Assignment will be rejected.

**Definition:** Calculated measures results for each episode of care (EOC) that is processed through a measure algorithm.

Used to summarize the outcome for an EOC that is processed through a specific measure algorithm.

**Suggested Data Collection Question:** Not Applicable

**Format:**
- **Length:** 1
- **Type:** Character
- **Occurs:** One Measure Category Assignment per EOC is expected for every measure that a hospital is participating in.

**Allowable Values:**

- **B** Category B - Not in Measure Population
  For rate-based and continuous variable measures: EOC record is not a member of a measure’s population.

- **D** Category D - In Measure Population
  For rate-based measures: EOC record is a member of the measure’s population and there has not been an occurrence of the measure.

**Note:** For measures for which better quality is associated with a lower score or numerator, i.e., VTE-6 and PC-01, a Measure Category Assignment of “D” means that the appropriate care was provided and the intent of the
measure was met. For aggregate data, the EOC record will be included in the measure denominator only.

For continuous variable measures: EOC record is a member of the measure's population and has sufficient accurate and valid data to compute the measurement.

**Note:** For continuous variable measures, EOC records that have a Measure Category Assignment of “D” will have an associated Measurement Value.

**E Category E - In Numerator Population**
For rate-based measures: EOC record is a member of the measure's population and there has been an occurrence of the measure.

**Note:** For measures for which better quality is associated with a lower score or numerator, i.e., VTE-6 and PC-01, a Measure Category Assignment of “E” means that the appropriate care was not provided and the intent of the measure was not met. For aggregate data, the EOC record will be included in both the measure numerator and denominator.

For continuous variable measures: Does not apply.

**X Category X – Data Are Missing**
For rate-based and continuous variable measures: Data are missing that is required to calculate the measure. The record will be rejected by the CMS Clinical Warehouse and the Joint Commission's Data Warehouse.

**Y Category Y – UTD Allowable Value Does Not Allow Calculation of The Measure**
For rate-based measures: Does not apply.

For continuous variable measures: EOC record contains a Date, Time, or Numeric data element with a Value of “UTD.”

**Note:** For continuous variable measures, EOC records that have a Measure Category Assignment of “Y” will not have an associated Measurement Value.

**Notes for Abstraction:**
None

**Suggested Data Sources:**
Not Applicable

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: *Measurement Value*

Collected For The Joint Commission Only: Used in the calculation of Continuous Variable Measures (ED-1, ED-2), and in the transmission of the Hospital Clinical Data file

Note:
- The ORYX® Vendor’s calculated *Measurement Value* will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in The Joint Commission’s data quality analysis and continuous measure verification process. ORYX Vendors can refer to The Joint Commission’s *ORYX Data Quality Manual* for more information.
- *Measurement Value* must be transmitted to The Joint Commission but cannot be transmitted to CMS. Files transmitted to the CMS Clinical Warehouse that contain *Measurement Value* will be rejected.

Definition: This data element is used to store the calculated results of the measurements that are outputs from continuous variable measure algorithms.

Note: Used in conjunction with Measure Category Assignment when its allowable value = “D” (In Measure Population).

Suggested Data Collection Question: Not Applicable

Format:
- **Length:** 6
- **Type:** Numeric
- **Occurs:** One *Measurement Value* is expected per EOC for every continuous variable measure that a hospital is participating in.

Allowable Values:
- Any valid number

Note: The allowable value range for each continuous variable measure is documented in that measure’s algorithm. Each measure may have a different allowable value range.

Notes for Abstraction:
None

Suggested Data Sources:
Not Applicable

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: *Patient Identifier*

Collected For CMS Only: All Records

Note: Refer to the Hospital Clinical Data XML File Layout in the Transmission section of this manual.

Definition: The number used by the hospital to identify this patient’s stay. The number provided will be used to identify the patient in communications with the hospital, e.g., Medical Record Number, Account Number, Unique Identifiable Number as determined by the facility, etc.

A patient identifier is required for data submitted to the CMS Clinical Data Warehouse.

Suggested Data Collection Question: What was the number used by the hospital to identify this patient’s stay?

Format:
- Length: 40
- Type: Character
- Occurs: 1

Allowable Values:
- Up to 40 letters, numbers, and/or characters.
  - Note: The only characters that will be allowed are spaces, hyphens, dashes and under-scores.

Notes for Abstraction:
None

Suggested Data Sources:
None

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Payment Source

Collected For CMS/The Joint Commission: All Records

Definition: The source of payment for this episode of care.

Suggested Data Collection Question: What is the patient’s source of payment for this episode of care?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1. Source of payment is Medicare.
2. Source of payment is Non-Medicare.

Notes for Abstraction:
- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list of payers, select “1.”
- If the patient has Medicaid only or Medicaid and another insurance type, other than Medicare, select “2.” If the patient has Medicaid and Medicare, select “1.”
- If the patient is an Undocumented Alien or Illegal immigrant, select “1.”

Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry and Mexican citizens permitted to enter the United States on a laser visa.

Suggested Data Sources:
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:
Medicare includes, but is not limited to:
- Black Lung
- End Stage Renal Disease (ESRD)
- Medicare Fee for Service (includes DRG or PPS)
- Medicare HMO/Medicare Advantage
- Medicare Secondary Payer
- Railroad Retirement Board (RRB)

Exclusion Guidelines for Abstraction:
None
Data Element Name: Persistent Hypotension

Collected For CMS: SEP-1

Definition: 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.

Suggested Data Collection Question: Was persistent hypotension or new onset of hypotension present within one hour of the conclusion of crystalloid fluid administration?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
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.

Notes for Abstraction:
- 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 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.
- Use the time the hypotensive blood pressures were taken or obtained. If time taken or obtained is not available, use recorded or documented time. Do not abstract hypotensive values from narrative charting unless there is no other documentation that reflects the time that the same hypotensive values were obtained.
- Hypotensive BPs obtained within the operating room (OR) should not be used.
• Hypotensive BPs documented from an orthostatic BP evaluation **should not be used.**

• Determining presence of persistent hypotension (low is SBP <90 or MAP <65):
  o 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.”
  o If there are more than two blood pressures documented, refer to the last two consecutive blood pressures within the hour:
    ▪ If there is a normal blood pressure followed by another normal blood pressure, select Value “2.”
    ▪ If there is a normal blood pressure followed by a low blood pressure, select Value “3.”
    ▪ If there is a low blood pressure followed by a normal blood pressure, select Value “2.”
    ▪ If there is a low blood pressure followed by another low blood pressure, select Value “1.”

• **For the following**, physician/APN/PA documentation prior to or within 24 hours after **Severe Sepsis Presentation Time** **is required.**
  o If hypotension (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it **should not be used.** Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation.
    ▪ Normal for that patient
    ▪ Is due to a chronic condition
    ▪ Is due to a medication
      **Example:**
      “Hypotensive after pain meds.”
  o If a hypotensive value is due to an acute condition that has a non-infectious source/process, it **should not be used** (Refer to **Severe Sepsis Present** criteria “a” to determine if the source of the acute condition is an infection).
    **Example:**
    “BP 85/50 r/t blood loss” “2 liters lost via GI bleed” (blood loss is the acute condition and GI bleed is the non-infectious source.
  o If a hypotensive value should not be used based on the above guidance, all instances of less severe values **should not be used.**
    **Example:**
    “BP 80/50 secondary to Lasix” (systolic blood pressures ≥ 80 would not be used).
  o If a hypotensive value is due to the following, the criteria value **should be used.**
    ▪ Acute condition
      **Example:**
      Progress Note: “Hypotension r/t dehydration.”
    ▪ Acute on chronic condition
      **Example:**
      H&P: “Hypotension due to acute exacerbation of chronic heart failure.”
- **Infection**

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

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

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

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

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

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

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

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

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

  - If the completion time of the target ordered volume is not documented in the medical record use the following criteria to determine the conclusion time.
    - If the order includes a time frame over which to infuse the crystalloid fluid, identify the time the fluids are started and add to that the duration identified in the order. This will represent the conclusion of crystalloid fluids.
      **Example:**
      An order for 1500 mL over 1 hour and the infusion is started at 10:00. Add 1 hour to the start time to determine infusion conclusion time of 11:00.
    - If the order includes a rate at which to infuse the crystalloid fluids, the end time can be calculated based on the volume, the rate and the start time.
      **Example:**
      An order for 1500 mL at 1000 mL/hour and the infusion is started at 10:00. The time over which 1500 mL is infused is the volume divided by the rate. 1500 mL divided by 1000 mL/hour is 1.5 hours. Add 1.5 hours to the start time to determine infusion conclusion time of 11:30.
    - If the order is for more than 30 mL/kg, 30 mL/kg will have been infused before the entire volume ordered is infused.
Example:
An order for 3000 mL over 2 hours, infusion started at 10:00. Patient weighs 80 kg, 30 mL/kg target volume is 2400 mL (as determined for Crystalloid Fluid Administration). Divide the total volume ordered by the infusion duration in minutes to determine the infusion rate (3000 mL/120 minutes = 25 mL/minute). Divide the 30 mL/kg target volume by the infusion rate to determine the number of minutes it takes to infuse the target volume (2400 mL/25 mL/min = 96 minutes). Add the number of minutes to infuse the target volume to the infusion start time to determine the time 30 mL/kg was completed (10:00 + 96 minutes = 11:36).

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

- Acceptable crystalloid fluids are identified in the Crystalloid Fluid Administration data element.
- If the end time of the target ordered volume of crystalloid fluids cannot be determined, select Value “3.”
- If crystalloid fluids were administered but at a volume less than the target ordered volume, choose Value “4.”
- Use of documentation in pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record is acceptable for determining the presence of Persistent Hypotension.
- If within 24 hours of the Severe Sepsis Presentation Time there is physician/APN/PA or nursing documentation indicating a hypotensive reading is erroneous or questioning the validity of a hypotensive reading, disregard that reading for determining the presence of persistent or new onset of hypotension.

Suggested Data Sources:
- Entire ED record
- Nurses notes
- Physician/APN/PA notes
- Vital signs record or flow sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Physician 1

Collected For CMS Only: All Records (Optional Element)

Definition: The first physician identifier

Suggested Data Collection Question: What is the first physician identifier?

Format:
   Length: 50
   Type: Character
   Occurs: 1

Allowable Values:
Enter the first physician identifier, as directed. Up to 50 letters, numbers, and/or special characters can be entered.

Note: Only the following special characters will be allowed:
   ~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = \ ; ' . , / and space

Notes for Abstraction:
This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources:
None

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: *Physician 2*

Collected For CMS Only: All Records (Optional Element)

Definition: A second physician identifier

Suggested Data Collection Question: What is the second physician identifier?

Format:
- **Length:** 50
- **Type:** Character
- **Occurs:** 1

Allowable Values:
Enter the second physician identifier, as directed. Up to 50 letters, numbers, and/or special characters can be entered.

**Note:** Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] ; ' . , / and space

Notes for Abstraction:
This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources:
None

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: *Postal Code*

Collected For CMS Only: All Records

**Definition:** The postal code of the patient’s residence. For the United States zip codes the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

**Suggested Data Collection Question:** What is the postal code of the patient’s residence?

**Format:**
- **Length:** 9
- **Type:** Character
- **Occurs:** 1

**Allowable Values:**
Any valid five or nine digit postal code or “HOMELESS” if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use “NON-US.”

**Notes for Abstraction:**
If the postal code of the patient is unable to be determined from medical record documentation, enter the provider’s postal code.

**Suggested Data Sources:**
- Face sheet
- UB-04

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: *Prescription for Alcohol or Drug Disorder Medication*

Collected For The Joint Commission Only: SUB-3

**Definition:** Documentation that an FDA-approved medication for alcohol or drug disorder was prescribed at hospital discharge.

**Suggested Data Collection Question:** Was one of the FDA-approved medications for alcohol or drug disorder prescribed at discharge?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
1. A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge.
2. A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused.
3. **The patient:**
   - is being discharged to a residence outside the USA
   - is released to a court hearing and does not return
   - is being discharged to jail/law enforcement
4. A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge, or unable to determine from medical record documentation.

**Notes for Abstraction**
- In determining whether a medication for alcohol or drug disorder was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Disulfiram, but this is not included in any of the other discharge medications sources, e.g., discharge orders. All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
- In cases where there is a medication for alcohol or drug disorder in one source and it is not mentioned on other sources, it should be interpreted as a discharge medication, select Value “1” unless documentation elsewhere in the medical record suggests that it was not prescribed at discharge.
- If documentation is contradictory (physician noted “d/c Antabuse” or “hold Antabuse” in the discharge orders, but Antabuse is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed unable to determine, select Value “4.”
- If the patient does not have a residence in the USA, Value “3” must be selected.
Suggested Data Sources:
- Discharge Instruction Sheet
- Discharge summary
- Medication Reconciliation Form
- Nursing Discharge notes
- Physician Orders Sheet
- Transfer sheet

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 9.2 for a comprehensive list of FDA-approved medications for alcohol and drug dependence

Exclusion Guidelines for Abstraction:
None
Data Element Name: Prescription for Tobacco Cessation Medication

Collected For The Joint Commission Only: TOB-3

Definition: Documentation that an FDA-approved tobacco cessation medication was prescribed at hospital discharge.

Suggested Data Collection Question: Was an FDA-approved tobacco cessation medication prescribed at discharge?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1 A prescription for an FDA-approved tobacco cessation medication was given to the patient at discharge.
2 A prescription for an FDA-approved tobacco cessation medication was offered at discharge and the patient refused.
3 The patient:
   - is being discharged to a residence outside the USA
   - is released to a court hearing and does not return
   - is being discharged to jail/law enforcement
4 A prescription for an FDA-approved tobacco cessation medication was not offered at discharge or unable to determine from medical record documentation.

Notes for Abstraction
- All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor. In determining whether a tobacco cessation medication was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Varenicline and this is not included in any of the other discharge medication sources (e.g., discharge orders). Select Value “1” unless documentation elsewhere in the medical record suggests that it (tobacco cessation medication) was not prescribed at discharge.
- If documentation is contradictory (physician noted “d/c Varenicline” or “hold Varenicline” in the discharge orders, but Varenicline is listed in the discharge summary’s discharge medication list) or after careful examination of circumstance, context, timing, etc., the documentation remains unclear, the case should be deemed unable to determine. Select Value “4.”
- If the physician wishes the patient to continue on medication that does not require a prescription (for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling or quit line), select Value “1” if the medication is listed on the discharge medication list.
• If NRT or a prescribed FDA-approved tobacco cessation medication is listed as a discharge medication but there is also documentation of refusal by the patient at discharge, select Value “2.”
• If the patient does not have a residence in the USA, Value “3” must be selected.
• If the patient refused tobacco cessation medication during the hospitalization, a prescription must be offered again at the time of discharge. Select Value “4” if documentation reflects that a prescription for cessation medication was not offered at the time of discharge.

**Suggested Data Sources:**
- Discharge instruction sheet
- Discharge summary
- Medication reconciliation form
- Nursing discharge notes
- Physician order sheet
- Transfer sheet

**Inclusion Guidelines for Abstraction:**
Refer to Appendix C, Table 9.1 for a comprehensive list of FDA-approved tobacco cessation medications

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Race

Collected For CMS/The Joint Commission: All Records

Definition: Documentation of the patient’s race.

Suggested Data Collection Question: What is the patient’s race?

Format:
- Length: 1
- Type: Character
- Occurs: 1

Allowable Values:
Select one:
1. White: Patient’s race is White, or the patient has origins in Europe, the Middle East, or North Africa.
2. Black or African American: Patient’s race is Black or African American.
3. American Indian or Alaska Native: Patient’s race is American Indian/Alaska Native.
4. Asian: Patient’s race is Asian.
5. Native Hawaiian or Pacific Islander: Patient’s race is Native Hawaiian/Pacific Islander.
6. RETIRED VALUE (effective 07-01-05 discharges)
7. UTD: Unable to determine the patient’s race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Notes for Abstraction:
- The data element Hispanic Ethnicity is required in addition to this data element.
- If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
- Although the terms “Hispanic” and “Latino” are actually descriptions of the patient’s ethnicity, it is not uncommon to find them referenced as race. If the patient’s race is documented only as Hispanic/Latino, select “White.” If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic – select “Black”). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.

Suggested Data Sources:
- Emergency Department record
- Face sheet
- History and physical
- Nursing admission assessment
- Progress notes
Inclusion Guidelines for Abstraction:

**Black or African American:** A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African.”

**American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American).

**Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).

**Native Hawaiian or Pacific Islander:** A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Exclusion Guidelines for Abstraction:
None
Data Element Name: *Reason for No Administration of VTE Prophylaxis*

Collected For The Joint Commission Only: VTE-6

**Definition:** Physician/APN/PA or pharmacist documentation why mechanical AND pharmacological VTE prophylaxis were not administered on the day(s) between arrival and the day before the *VTE Diagnostic Test* order date. Both mechanical and pharmacological prophylaxis must be addressed.

**Suggested Data Collection Question:** Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered on the day(s) between arrival and the day before the *VTE Diagnostic Test* order date?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **Y** (Yes) There is physician/APN/PA or pharmacist documentation why mechanical AND pharmacological VTE prophylaxis were not administered on the day(s) between arrival and the day before the *VTE Diagnostic Test* order date.
- **N** (No) There is no physician/APN/PA or pharmacist documentation why mechanical AND pharmacological VTE prophylaxis were not administered on the day(s) between arrival and the day before the *VTE Diagnostic Test* order date, or unable to determine from medical record documentation.

**Notes for Abstraction:**
- To select “Yes” for this data element, documentation of a reason for not administering mechanical AND pharmacological VTE prophylaxis must be dated between hospital arrival and the day before the *VTE Diagnostic Test* order date. Refer to the data element *VTE Diagnostic Test* for a list of acceptable tests.
- Reasons for not prescribing VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.

**EXCEPTIONS:**
- Patient/family refusal may be documented by a nurse, but should be documented within the same time frame as the reason for no VTE prophylaxis. Patient/family refusal of any form of prophylaxis is acceptable to select “Yes.” For example, “patient refused heparin,” select “Yes.”
- A validated risk assessment may be documented by a nurse, but should be documented within the same time frame as the reason for no administration of VTE prophylaxis.
For patients receiving anticoagulant therapy, including continuous IV heparin infusion, the day before the VTE diagnostic test order date, select “Yes.” Disregard IV heparin administered to flush/maintain patency of a line or dialysis equipment and IV heparin administered during an interventional procedure, e.g., cardiac cath.

- If reasons are not mentioned in the context of VTE prophylaxis, do not make inferences (e.g., do not assume that VTE Prophylaxis was not administered because of a bleeding disorder unless documentation explicitly states so).
  
  **Example:**
  Physician/APN/PA documentation of bleeding risk, review the chart for documentation about reasons for no mechanical AND no pharmacological VTE prophylaxis.

- If the VTE Diagnostic Test was performed the day of or the day after arrival, select “Yes.”

- Documentation that a formal risk assessment was administered, AND the results indicated that there was no risk or low risk for VTE is acceptable as a reason for not administering VTE prophylaxis.
  - If a copy of the validated risk assessment is included in the medical record along with the results, select “Yes.”
  - Documentation of a low risk score without a copy of the validated risk assessment is acceptable, if the validated risk assessment tool used is mentioned in the note. See Inclusion Guidelines for Abstraction.
  - Documentation of low risk or no risk without mention of a score and the validated risk assessment tool, select “No.”

- If two physicians/APN/PA or pharmacist document conflicting or questionable needs for prophylaxis, select “No.”

**SUGGESTED DATA SOURCES:**
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT ADMINISTERING VTE PROPHYLAXIS:

- Anesthesia record
- Consultation notes
- Emergency department record
- History and physical
- Physician orders
- Physician progress notes
- Transfer form

**SUGGESTED DATA SOURCES FOR PATIENT REFUSAL** (other than physician/APN/PA or pharmacist) documentation of a reason for not administering VTE prophylaxis as above):

- Medication administration record
- Nurses notes
Inclusion Guidelines for Abstraction:
Explicit documentation that the patient does not need VTE prophylaxis

ALL INCLUSIVE VALIDATED RISK ASSESSMENTS:
- Caprini DVT Risk Assessment
- Padua Prediction Score
- International Medical Prevention Registry on Venous Thromboembolism (IMPROVE)

LOW RISK SCORES:
- Caprini score of 0 (zero) – no need for prophylaxis.
- IMPROVE score of 0 (zero) or 1 (one); or a probability of less than 1.5%
- Padua score of less than 4 (0-3)

Refer to Appendix H, Table 2.7 Anticoagulation Therapy

Exclusion Guidelines for Abstraction:
Risk Assessment tools other than Caprini, Padua, and IMPROVE
Data Element Name: *Reason for No Tobacco Cessation Medication at Discharge*

Collected For The Joint Commission Only: TOB-3

**Definition:** Reasons for not prescribing an FDA-approved tobacco cessation medication at discharge include:
- Allergy to all of the FDA-approved tobacco cessation medications.
- Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking.
- Patient is pregnant.
- Other reasons documented by physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist.

**Suggested Data Collection Question:** Is there documentation of a reason for not prescribing one of the FDA-approved tobacco cessation medications at discharge?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **Y (Yes)** There is documentation of a reason for not prescribing an FDA-approved cessation medication at discharge.
- **N (No)** There is no documentation of a reason for not prescribing an FDA-approved cessation medication at discharge or unable to determine from medical record documentation.

**Notes for Abstraction**
- Reasons (other than pregnancy) for not prescribing FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.
- If there is any documentation in the medical record indicating the patient is pregnant, select “Yes.”
- An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not prescribing another of the cessation medications.
- In determining whether there is a reason documented by physician/APN/PA or pharmacist for not prescribing tobacco cessation medications, the reason must be explicitly documented (e.g., “No tobacco cessation medication as patient is post-operative and nicotine may place them at risk for impaired wound healing”) or clearly implied (e.g., “Patient becomes anxious when they take tobacco cessation medication”). If reasons are not mentioned in the context of cessation medication, do not make inferences (e.g., Do not assume that a tobacco cessation medication is not being prescribed because of the patient's history of recent surgery alone).
- When conflicting information is documented in the medical record, select Value “No.”
• If the reason for not prescribing FDA-approved cessation medication is documented at any time during the hospitalization, additional documentation of the reason at the time of discharge is not required.
• Documentation by the physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist that the patient refused tobacco cessation medication is not considered a valid reason for no tobacco cessation medication at discharge. If refusal is documented as the reason, select Value “No.”

Suggested Data Sources:
• Anesthesia record
• Consultation record
• Discharge summary
• Emergency Department record
• History and physical
• Medication administration record (MAR)
• Physician orders
• Progress notes
• Transfer form

Inclusion Guidelines for Abstraction:
Allergy or sensitivity

Refer to Appendix C, Table 9.1 for a list of FDA-approved tobacco cessation medications

Exclusion Guidelines for Abstraction:
Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)
Data Element Name: *Reason for No Tobacco Cessation Medication During the Hospital Stay*

Collected For The Joint Commission Only: TOB-2

**Definition:** Reasons for not administering an FDA-approved tobacco cessation medication documented during the hospital stay include:

- Allergy to all of the FDA-approved tobacco cessation medications.
- Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking.
- Patient is pregnant.
- Other reasons documented by physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist.

**Suggested Data Collection Question:** Is there documentation of a reason for not administering one of the FDA-approved tobacco cessation medications during the hospital stay?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **Y (Yes)**: There is documentation of a reason for not administering an FDA-approved cessation medication during the hospital stay.
- **N (No)**: There is no documentation of a reason for not administering an FDA-approved cessation medication during the hospital stay or unable to determine from medical record documentation.

**Notes for Abstraction**

- Reasons (other than pregnancy) for not administering FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.
- If there is any documentation in the medical record indicating the patient is pregnant, select “Yes.”
- An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not administering another of the cessation medications.
- In determining whether there is a reason documented by physician/APN/PA or pharmacist for not administering tobacco cessation medications, the reason must be explicitly documented (e.g., “No tobacco cessation medication as patient is post-operative and nicotine may place them at risk for impaired wound healing”) or clearly implied (e.g., “Patient becomes anxious when they take tobacco cessation medication”). If reasons are not mentioned in the context of cessation medication, do not make inferences (e.g., Do not assume that a tobacco cessation medication is not being prescribed because of the patient’s history of recent surgery alone).
• When conflicting information is documented in the medical record, select Value “No” for the indicated reasons present for not administering the tobacco cessation medications.
• Documentation by the physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist that the patient refused tobacco cessation medication is not considered a valid reason for no tobacco cessation medication during the hospitalization. If refusal is documented as the reason, select Value “No.”

**Suggested Data Sources:**
- Anesthesia record
- Consultation record
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record (MAR)
- Physician orders
- Progress notes
- Transfer form

**Inclusion Guidelines for Abstraction:**
Allergy or sensitivity

Refer to Appendix C, Table 9.1 for a list of FDA-approved tobacco cessation medications

**Exclusion Guidelines for Abstraction:**
Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)
Data Element Name: *Referral for Addictions Treatment*

Collected For The Joint Commission Only: SUB-3

**Definition:** Documentation that a referral was made at discharge for addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor). A referral is defined as an appointment made by the provider either through telephone contact, fax or e-mail. The referral may be to an addictions treatment program, to a mental health program or mental health specialist for follow-up for substance use or addiction treatment, or to a medical or health professional for follow-up for substance use or addiction.

**Suggested Data Collection Question:** Was a referral for addictions treatment made for the patient prior to discharge?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
1. The referral to addictions treatment was made by the healthcare provider or health care organization at any time prior to discharge.
2. Referral information was given to the patient at discharge, but the appointment was not made by the provider or health care organization prior to discharge.
3. The patient refused the referral for addictions treatment and the referral was not made.
4. The patient:
   - is being discharged to a residence outside the USA
   - is released to a court hearing and does not return
   - is being discharged to jail/law enforcement
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:**
- 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.
- If the patient does not have a residence in the USA, Value “4” must be selected.
- Select Value “5” if:
  - it cannot be determined that a referral for addictions treatment was made or;
  - it is unclear that the absence of the referral was due to a patient refusal or;
  - a referral was not offered.
Suggested Data Sources:
- Discharge instruction sheet
- Discharge summary
- Nursing discharge notes
- Physician order sheet
- Transfer sheet

Inclusion Guidelines for Abstraction:
- Group counseling
- Individual counseling
  - Addictions counselor
  - Personal physician
  - Psychiatrist
  - Psychologist

Exclusion Guidelines for Abstraction:
- Self-help interventions in the form of printed/electronic/digital media
- Support groups that are not considered treatment such as Alcoholics Anonymous (AA)
Data Element Name: Referral for Outpatient Tobacco Cessation Counseling

Collected For The Joint Commission Only: TOB-3

Definition: Documentation that a referral was made at discharge for ongoing evidence-based counseling with clinicians (physician or non-physician such as nurse, psychologist, counselor). Outpatient counseling may include proactive telephone counseling, group counseling and/or individual counseling. A counseling referral is defined as an appointment made by the healthcare provider or hospital either through telephone contact, fax, the EHR or e-mail. For quitline referrals, the healthcare provider or hospital can either fax or e-mail a quitline referral or assist the patient in directly calling the quitline prior to discharge.

Suggested Data Collection Question: Did the patient receive a referral for Outpatient Tobacco Cessation Counseling?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1 The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider or health care organization at any time prior to discharge.
2 Referral information was given to the patient at discharge, but the appointment was not made by the provider or health care organization prior to discharge.
3 The patient refused the referral for outpatient tobacco cessation counseling treatment and the referral was not made.
4 The patient:
   - is being discharged to a residence outside the USA
   - is released to a court hearing and does not return
   - is being discharged to jail/law enforcement
5 The referral for outpatient tobacco cessation counseling treatment was not offered at discharge or unable to determine from the medical record documentation.

Notes for Abstraction:
- If a referral is made to a Quitline, defined as a telephone counseling in which at least some of the contact is initiated by the Quitline counselor to deliver tobacco use interventions, select Value “1.” If the patient directly calls the Quitline during the hospitalization, documentation must reflect that staff was present during the call to verify that an appointment was set.
• If the patient is provided with contact information for e-health or internet smoking cessation programs which tailor program content to the tobacco user’s needs (by collecting information from the tobacco user and using algorithms to tailor feedback or recommendations, permitting the user to select from various features including extensive information on quitting, tobacco dependence, and related topics) select Value “2.” Note that if Value “2” is selected, the case will not pass the measure. Value “2” can be used as part of an internal performance improvement activity in order to determine if any type of referral was made rather than no referral.

• If the patient is provided with self-help materials that are not tailored to the patient’s needs and do not provide a structured program, select Value “5.”

• Select Value “5” if:
  o it cannot be determined that a referral for outpatient cessation counseling was made or;
  o it is unclear that the absence of the referral was due to a patient refusal or;
  o a referral was not offered.

• If the patient does not have a residence in the USA, Value “4” must be selected.

• 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.

**Suggested Data Sources:**
- Discharge instruction sheet
- Discharge summary
- Nursing discharge notes
- Physician order sheet
- Transfer sheet

**Inclusion Guidelines for Abstraction:**
- Group counseling
- Individual counseling
- Quitline

**Exclusion Guidelines for Abstraction:**
- E-health
- Internet structured programs
- Self-help interventions in the form of printed/electronic/digital media
Data Element Name: Repeat Lactate Level Collection

Collected For CMS: SEP-1

Definition: Documentation of obtaining a repeat lactate level in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter. A repeat lactate level is the level drawn following the initial level.

Suggested Data Collection Question: Was a repeat lactate level drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- 1 (Yes) A repeat lactate level was drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter.
- 2 (No) A repeat lactate level was not drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter, or unable to determine.

Notes for Abstraction:
- A repeat lactate level is the next lactate level drawn after the initial lactate level if the initial lactate is elevated (>2.0 mmol/L). This repeat level must be drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter to choose Value “1.”
- If a repeat lactate level was drawn but not in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter, choose Value “2.”
- Do not use documentation such as “Labs Drawn” as it is not specific for lactate level. Similarly, do not use a physician order for lactate levels as it does not specify that lactate level was drawn, unless there is a notation next to the order that it was drawn or collected.
- If there is no documentation indicating a repeat lactate was drawn or collected, it is acceptable to use supporting documentation indicating that a repeat lactate was drawn (e.g., lactate sent to lab, lactate received, lactate result). If there are multiple instances of supporting documentation, use the earliest.
- If a repeat lactate level is ordered and there is an attempt to collect it, but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, select Value “1.”

Suggested Data Sources:
- Laboratory Reports
- Nursing Notes
- Physician/APN/PA notes or orders
Inclusion Guidelines for Abstraction:
- Lactate drawn
- Lactate level collected
- Lactic acid drawn

Exclusion Guidelines for Abstraction:
Labs drawn
Data Element Name: *Repeat Lactate Level Date*

Collected For CMS: SEP-1

Definition: The date on which the repeat lactate level was drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter.

Suggested Data Collection Question: What was the earliest date on which the repeat lactate level was drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter?

Format:
- Length: 10 – MM-DD-YYYY (includes dashes) or UTD
- Type: Date
- Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

Notes for Abstraction:
- A repeat lactate level is the next lactate level drawn after the initial lactate level if the initial lactate is elevated (>2.0 mmol/L). This repeat level must be drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter.
- Do not use documentation such as “Labs Drawn” as it is not specific for lactate level. Similarly, do not use a physician order for lactate levels as it does not specify that lactate level was drawn, unless there is a notation next to the order that it was drawn or collected and there is a date noted.
- If there is no documentation indicating a repeat lactate was drawn or collected, it is acceptable to use supporting documentation indicating that a repeat lactate was drawn (e.g., lactate sent to lab, lactate received, lactate result). If there are multiple instances of supporting documentation, use the earliest.
- If a repeat lactate level is ordered and there is an attempt to collect it, but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, enter the date of the attempted lactate collection.

Suggested Data Sources:
- Laboratory Reports
- Nursing Notes
- Physician/APN/PA notes or orders
Inclusion Guidelines for Abstraction:
- Lactate level collected
- Lactate level drawn
- Lactic acid drawn

Exclusion Guidelines for Abstraction:
- Labs drawn
- Labs reported
Data Element Name: Repeat Lactate Level Time

Collected For CMS: SEP-1

Definition: The earliest time at which a repeat lactate level was drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter.

Suggested Data Collection Question: What was the earliest time at which a repeat lactate level was drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter?

Format:
- Length: 5 - HH:MM (with or without colon) or UTD
- Type: Time
- Occurs: 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight – 00:00  
- Noon – 12:00
- 5:31 am – 05:31  
- 5:31 pm – 17:31
- 11:59 am – 11:59  
- 11:59 pm – 23:59

Notes for Abstraction:
- A repeat lactate level is the next lactate level drawn after the initial lactate level if the initial lactate is elevated (>2.0 mmol/L). This repeat level must be drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter.
- Do not use documentation such as “Labs Drawn” as it is not specific for lactate level. Similarly, do not use a physician order for lactate levels as it does not specify that lactate level was drawn, unless there is a notation next to the order that it was drawn or collected and there is a time noted.
- If there is no documentation indicating a repeat lactate was drawn or collected, it is acceptable to use supporting documentation indicating that a repeat lactate was drawn (e.g., lactate sent to lab, lactate received, lactate result). If there are multiple instances of supporting documentation, use the earliest.
- If a repeat lactate level is ordered and there is an attempt to collect it, but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, enter the time of the attempted lactate collection.
**Suggested Data Sources:**
- Laboratory Reports
- Nursing Notes
- Physician/APN/PA notes or orders

**Inclusion Guidelines for Abstraction:**
- Lactate level collected
- Lactate level drawn
- Lactic acid drawn

**Exclusion Guidelines for Abstraction:**
- Labs drawn
- Labs reported
Data Element Name: *Repeat Volume Status and Tissue Perfusion Assessment Performed*

Collected For CMS: SEP-1

Definition: Documentation indicating that a repeat volume status and tissue perfusion assessment was performed to assess the patient's response to the administration of crystalloid fluids.

Suggested Data Collection Question: Was a repeat volume status and tissue perfusion assessment documented in the appropriate time window?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- 1 (Yes) Repeat Volume Status and Tissue Perfusion Assessment was documented in the appropriate time window.
- 2 (No) Repeat Volume Status and Tissue Perfusion Assessment was not documented in the appropriate time window, or unable to be determined.

Notes for Abstraction:
- Start abstracting at the crystalloid fluid administration date and time and stop abstracting six hours after the presentation of septic shock date and time. This is the appropriate time window.
- A repeat volume status and tissue perfusion assessment may consist of any one of the following three:
  - Physician/APN/PA documentation indicating or attesting to performing or completing a physical examination, perfusion (re-perfusion) assessment, sepsis (severe sepsis or septic shock) focused exam, or systems review. Examples of Physician/APN/PA documentation that is acceptable:
    - "I did the Sepsis reassessment"
    - Flowsheet question: "Sepsis focused exam performed?" and selection of "Yes"
    - "Review of systems completed"
    - "I have reassessed tissue perfusion after bolus given."
    - "Sepsis re-evaluation was performed"
  - Physician/APN/PA documentation indicating or attesting to performing or completing a review of at least five of the following eight parameters. Reference to the parameters must be made in physician/APN/PA documentation. Parameters do not need to all be contained within the same physician/APN/PA documentation.
- **Arterial Oxygen Saturation**  
  - Must be documented as from an arterial source, referenced as arterial oxygen saturation, oxygen saturation, pulse oximetry, POx, or using the abbreviation SaO2 (arterial oxygen saturation) or SpO2 (oxygen saturation measured by pulse oximetry).

- **Capillary Refill**  
  - Minimally includes documentation of a capillary refill test. (e.g., capillary refill 3 seconds, cap refill normal).

- **Cardiopulmonary Assessment**  
  - Minimally includes description of heart rate and rhythm, and results of auscultation of lungs. (e.g., heart normal rate & rhythm and lungs clear to auscultation, patient tachycardic and lungs decreased in bases)

- **Peripheral Pulses**  
  - Minimally includes documentation of presence or lack of presence of peripheral pulses (e.g., pulses present bilaterally, peripheral pulses faint, unable to palpate radial pulses).

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

- **Skin Color or Condition**  
  - Minimally includes either a description of the skin color or condition (e.g., skin cool and clammy, peripheral cyanosis, skin pink and warm, patient appears pale, skin normal, skin normal for ethnicity).

- **Urine Output (UO)**  
  - Physician/APN/PA documentation must reference urine output.
  - Documentation of the urine output volume is not required.

- **Vital Signs**  
  - Minimally includes documentation referencing heart rate (HR) respiratory rate (RR), blood pressure (BP) and temperature (temp or t).
  - Values for these vital signs are not required.

  - Documentation demonstrating one of the following was measured or performed. This documentation can be met by physician/APN/PA or non-physician/APN/PA documentation of performance of the test, a result or value. Physician/APN/PA attestation to having reviewed the test is acceptable.
    - **Central Venous Pressure (CVP).**
    - **Central Venous Oxygen Saturation (ScvO2 or SvO2).**
      - If documentation indicates the oxygen saturation is not from a central line source such as a peripheral venous blood gas do not use it.
    - **Echocardiogram (Cardiac echo or cardiac ultrasound).**
      - An order for an echocardiogram is not sufficient.
- Fluid Challenge or Passive Leg Raise.
  - Documentation must explicitly indicate a “fluid challenge” or “passive leg raise” or “leg raise” was performed.
  - If there are no repeat volume status and tissue perfusion assessment documented within the appropriate time window, choose Value “2.”

**Suggested Data Sources:**
- Cardiovascular ultrasound or echocardiogram report
- Consultation notes
- Critical Care flow sheet
- Emergency Department record
- History and physical
- Nurses notes
- Physician/APN/PA notes
- Procedure notes
- Respiratory Therapy notes or flow sheet
- Vital signs flow sheet

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Repeat Volume Status and Tissue Perfusion Assessment Performed Date

Collected For CMS: SEP-1

Definition: Documentation of the date indicating a repeat volume status and tissue perfusion assessment was performed.

Suggested Data Collection Question: On what date was a repeat volume status and tissue perfusion assessment documented by a physician/APN/PA?

Format:
- Length: 10 – MM-DD-YYYY (includes dashes) or UTD
- Type: Date
- Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

Notes for Abstraction:
- 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.
- Documentation of what constitutes or is acceptable for a repeat volume status and tissue perfusion assessment is defined in the Repeat Volume Status and Tissue Perfusion Assessment Performed data element.
- If there are multiple repeat volume status and tissue perfusion assessments performed, abstract the date of the latest assessment documented within the appropriate time window.
- If the repeat volume status and tissue perfusion assessment is in a physician/APN/PA note without a specific date documented within the note, use the date the note was started or opened.

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY
- Consultation notes
- Emergency Department record
- History and physical
- Progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: *Repeat Volume Status and Tissue Perfusion Assessment Performed Time*

Collected For CMS: SEP-1

Definition: Documentation of the time indicating a repeat volume status and tissue perfusion assessment was performed.

Suggested Data Collection Question: At what time was a repeat volume status and tissue perfusion assessment documented by a physician/APN/PA?

Format:
- **Length:** 5 - HH-MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight – 00:00  Noon – 12:00
- 5:31 am – 05:31  5:31 pm – 17:31
- 11:59 am – 11:59  11:59 pm – 23:59

Notes for Abstraction:
- 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.
- Documentation of what constitutes or is acceptable for a repeat volume status and tissue perfusion assessment is defined in the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element.
- If there are multiple repeat volume status and tissue perfusion assessments performed, abstract the time of the latest assessment documented within the appropriate time window.
- If the repeat volume status and tissue perfusion assessment is in a physician/APN/PA note without a specific date documented within the note, use the time the note was started or opened.
Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY
- Consultation notes
- Emergency Department record
- History and physical
- Progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
**Data Element Name:** Sample

**Collected For CMS/The Joint Commission:** All Records (Used in transmission of The Joint Commission’s aggregate data file and the Hospital Clinical Data file.)

**Notes:**
- Required for transmission of individual case data to the CMS Clinical Warehouse. Refer to the Hospital Clinical Data XML File Layout in the Transmission section of this manual.
- Required for transmission of aggregate data to The Joint Commission. Refer to the ORYX Technical Implementation Guide for more information.

**Definition:** Indicates if the data being transmitted for a hospital has been sampled, or represent an entire population for the specified time period.

**Suggested Data Collection Question:** Does this case represent part of a sample?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **Y (Yes)** The data represents part of a sample.
- **N (No)** The data is not part of a sample; this indicates the hospital is performing 100 percent of the discharges eligible for this measure set.

**Notes for Abstraction:**
When Sampling Frequency equals “3” (No, the hospital is not sampling) or “4” (N/A, submission of patient level data is not required), then abstract Sample as “No.”

**Suggested Data Sources:**
Not Applicable

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Septic Shock Present

Collected For CMS: SEP-1

Definition: Documentation of the presence of septic shock.

Suggested Data Collection Question: Is there documentation of the presence of septic shock?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1 (Yes) Septic Shock is present.
2 (No) Septic Shock is not present, or unable to determine.

Notes for Abstraction:
- Presence of Septic Shock may be identified based upon clinical criteria OR physician/APN/PA documentation of Septic Shock.
- If clinical criteria for Septic Shock are NOT met, but there is physician/APN/PA documentation of Septic Shock, choose Value “1.”
- In order to establish the presence of Septic Shock by clinical criteria, one of following two criteria (a or b) must be met:
  a. Severe Sepsis Present
     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.

- Hypotensive BPs obtained within the operating room (OR) should not be used.
- Hypotensive BPs documented from an orthostatic BP evaluation should not be used.
- Use the time the hypotensive blood pressures were taken or obtained. If time taken or obtained is not available, use recorded or documented time. Do not abstract hypotensive values from narrative charting unless there is no other documentation that reflects the time that the same hypotensive values were obtained.
- For the following, physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time is required.
  - If hypotension (SBP <90 mmHg or MAP <65 mmHg) is due to the following, it should not be used. Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation.
    - Normal for that patient
    - Is due to a chronic condition
    - Is due to a medication
    
    Example: "Hypotensive after pain meds"
  - If a hypotensive value is due to an acute condition that has a non-infectious source/process, it should not be used (Refer to Severe Sepsis Present criteria “a” to determine if the source of the acute condition is an infection).
    
    Example: "BP 85/50 r/t blood loss" “2 liters lost via GI bleed” (blood loss is the acute condition and GI bleed is the non-infectious source).
  - If a hypotensive value should not be used based on the above guidance, all instances of less severe values should not be used.
    
    Example: "BP 80/50 secondary to Lasix" (systolic blood pressures ≥ 80 would not be used).
  - If a hypotensive value is due to the following, the criteria value should be used.
    - Acute condition
      
      Example: Progress Note: “Hypotension r/t dehydration.”
    - Acute on chronic condition
      
      Example: H&P: “Hypotension due to acute exacerbation of chronic heart failure.”
    - Infection
      
      Example: Physician Note: “Sepsis, hypotensive.”
  - Documentation of a term that represents or is defined by a SBP <90 mmHg or MAP <65 mmHg is acceptable in place of an abnormal value.
    
    Example: Hypotension (Systolic blood pressure <90 mmHg)
• If within the same physician/APN/PA documentation, there is conflicting documentation indicating hypotension is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, the criteria value should be used.
  
  Example:
  "Hypotensive post medications, possibly r/t sepsis."

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

• If within 24 hours after the Severe Sepsis Presentation Time there is physician/APN/PA or nursing documentation that a hypotensive reading is invalid, erroneous or questionable, disregard that reading when determining the presence of Septic Shock.

• If Septic Shock presentation is more than six hours after Severe Sepsis Presentation Time, choose Value “2.”

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

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

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

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

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

• For documentation of Septic Shock accompanied by a qualifier, the table below should be used. Documentation containing a positive qualifier should be used to meet criteria, documentation containing a negative qualifier should not be used to meet criteria. Documentation containing both a positive and negative qualifier should not be used to meet criteria.
<table>
<thead>
<tr>
<th>Positive Qualifiers</th>
<th>Negative Qualifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible</td>
<td>Impending</td>
</tr>
<tr>
<td>Rule out (r/o)</td>
<td>Unlikely</td>
</tr>
<tr>
<td>Suspected</td>
<td>Doubt</td>
</tr>
<tr>
<td>Likely</td>
<td>Risk for</td>
</tr>
<tr>
<td>Probable</td>
<td>Ruled out</td>
</tr>
<tr>
<td>Differential Diagnosis</td>
<td>Evolving</td>
</tr>
<tr>
<td>Suspicious for</td>
<td>Questionable</td>
</tr>
<tr>
<td>Concern for</td>
<td></td>
</tr>
</tbody>
</table>

**Suggested Data Sources:**
- Any physician/APN/PA documentation
- Entire ED record
- Hourly output record
- Intake/Output record
- Laboratory results
- Nurses notes
- Vital signs record or flow sheet

**Inclusion Guidelines for Abstraction:**
- Septic Shock
- Severe Sepsis with Shock

**Exclusion Guidelines for Abstraction:**
- Bacteremia
- Septicemia
- Shock (not referenced as related to Severe Sepsis or Septic Shock)
Data Element Name: Septic Shock Presentation Date

Collected For CMS: SEP-1

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

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

Format:
- Length: 10 – MM-DD-YYYY (includes dashes) or UTD
- Type: Date
- Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

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

- If septic shock is in a physician/APN/PA note without a specific date documented within the note or documented using the acronym POA, the following apply:
  - If it is the only documentation of Septic Shock in the note, use the date the note was started or opened.
  - If Septic Shock is documented multiple times within the same note, use the earliest specified date.

**Suggested Data Sources:**
- Any physician/APN/PA documentation
- Entire ED record
- Hourly output record
- Intake/Output record
- Laboratory results
- Nurses notes
- Vital signs record or flow sheet

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Septic Shock Presentation Time

Collected For CMS: SEP-1

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

Suggested Data Collection Question: What was the time at which the last criterion was met to establish the presence of septic shock?

Format:
- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight – 00:00
- Noon – 12:00
- 05:31 am – 05:31
- 05:31 pm – 17:31
- 11:59 am – 11:59
- 11:59 pm – 23:59

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

• If septic shock is in a physician/APN/PA note without a specific time documented within the note or documented using the acronym POA, the following applies:
  o If it is the only documentation of Septic Shock in the note, use the time the note was started or opened.
  o If Septic Shock is documented multiple times within the same note, use the earliest specified time.

**Suggested Data Sources:**
• Any physician/APN/PA documentation
• Entire ED record
• Hourly output record
• Intake/Output record
• Laboratory results
• Nurses notes
• Vital signs record or flow sheet

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Severe Sepsis Present

Collected For CMS: SEP-1

Definition: Documentation of the presence of severe sepsis.

Suggested Data Collection Question: Was severe sepsis present?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1 (Yes) Severe Sepsis was present.
2 (No) Severe Sepsis was not present, or Unable to Determine.

Notes for Abstraction:
- Presence of Severe Sepsis may be identified based upon clinical criteria or physician/APN/PA documentation of Severe Sepsis.
- In order to establish the presence of Severe Sepsis by clinical criteria, all three clinical criteria (a, b, and c) must be met within 6 hours of each other. The three clinical criteria do not need to be documented in any particular order.
  a. Documentation of an infection.
    - Physician/APN/PA or nursing documentation referencing the presence of an infection is acceptable.
    - Physician/APN/PA, nursing, or pharmacist documentation indicating a patient is being treated with an antibiotic for an infection and that antibiotic is documented as administered within 6 hours of criteria b or c is acceptable (e.g., Levaquin is documented in MAR for pneumonia and nursing documentation within 6 hours of criteria b and c that indicates a dose was given).
    - If documentation of an infection is in a physician/APN/PA, nursing, or pharmacist note without a specific date and time or documented using the acronym POA, use the date and time the note was started or opened.
    - If the note states an infection was present on arrival, use the earliest documented arrival date and time.
    - If the note states an infection was present on admission, use the earliest documented date and time that the patient arrives to the floor or unit for admission.
    - If an infection is documented and within 6 hours following the initial documentation of the infection, there is additional physician/APN/PA documentation indicating the infection is not present, disregard the initial documentation of the infection.
Examples:
  o 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.
  o 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 Do not use hypotensive BPs documented from an orthostatic BP evaluation.
  • Systolic blood pressure decrease of more than 40 mmHg.
• Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, Severe Sepsis or Septic Shock and not other causes.

• Acute respiratory failure as evidenced by a new need for invasive or non-invasive mechanical ventilation.
  o Documentation the patient is on mechanical ventilation.
  o Invasive mechanical ventilation requires an endotracheal or tracheostomy tube. Non-invasive mechanical ventilation may be referred to as BiPAP or CPAP.
  o 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.
  o Use the time mechanical ventilation was initiated or the time the mechanical ventilation changed from intermittent to continuous.

• Creatinine >2.0
  o If there is physician/APN/PA documentation prior to or within 24 hours following presentation of severe sepsis that the patient has end stage renal disease (ESRD) and is on hemodialysis or peritoneal dialysis all reported creatinine levels should be disregarded as signs of organ dysfunction. ESRD (on hemodialysis or peritoneal dialysis) and creatinine levels or reference to elevated creatinine levels do not need to be included in the same physician/APN/PA documentation.
  o If there is physician/APN/PA documentation prior to or within 24 hours following presentation of severe sepsis of chronic renal disease (e.g., CKD I, II, or III, or “chronic renal insufficiency”) and the baseline creatinine is documented, creatinine values elevated >0.5 above baseline should be used as organ dysfunction (e.g., baseline 2.30, creatinine now 2.81).

• Urine output <0.5 mL/kg/hour for 2 consecutive hours
  o 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
  o If the suggested data source shows the patient was given an anticoagulant medication in Appendix C Table 5.3, an elevated INR or aPTT level should not be used as organ dysfunction. Physician/APN/PA documentation is not required.

• Lactate >2 mmol/L (18.0 mg/dL)

• For the following, physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time is required.
If the SIRS criteria or a sign of organ dysfunction is due to the following, it **should not be used**. Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation.

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

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

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

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

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

**Examples:**
- “Platelet count 75 r/t chemo” (platelet counts ≥ 75 would not be used).
- “Cr 2.8, CKD” (creatinine values ≤ 2.8 would not be used).

If SIRS criteria or a sign of organ dysfunction is due to the following, the criteria value **should be used**.

**Examples:**
- Acute condition
  - Progress Note: “Lactate 4.3 r/t seizure.”
  - H&P: “AKI, dehydration, creatinine 3.8.”
- **Acute on chronic condition**
  
  **Examples:**
  - H&P: “Acute on chronic renal failure, creatinine 2.8.”
  - Progress Note: “Hypotension due to acute exacerbation of chronic heart failure.”

- **Infection**
  
  **Example:**
  - Physician Note: “Cholecystitis with Hyperbilirubinemia.”
  - Antibiotic Order Indication: “Cholecystitis” (The antibiotic indication confirms cholecystitis is an infection).

- **Documentation of a term that represents or is defined by a SIRS criteria or sign of organ dysfunction is acceptable in place of an abnormal value.**
  
  **Examples** include but are not limited to:
  - Tachypnea (Respiration >20 per minutes)
  - A-fib with tachycardia, A-fib with RVR, or tachycardia (Heart rate >100)
  - Leukopenia (White blood cell count <4,000)
  - Leukocytosis (White blood cell count >12,000)
  - Thrombocytopenia (Platelet count <100,000)
  - Hypotension (Systolic blood pressure <90 mmHg)

- **If within the same physician/APN/PA documentation, there is conflicting documentation indicating SIRS criteria or sign of organ dysfunction is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, the criteria value should be used.**
  
  **Examples:**
  - “Creatinine 4.3, CKD, potentially increasing due to worsening UTI,” creatinine value should be used.
  - “Thrombocytopenia possibly due to NSAID use, however complicated by sepsis,” platelet value should be used.

- **If within 24 hours after Severe Sepsis Presentation Time there is conflicting information within two or more separate pieces of physician/APN/PA documentation indicating SIRS criteria or sign of organ dysfunction is normal for the patient, or due to a chronic condition or medication AND due to or possibly due to an infection, Severe Sepsis, or Septic Shock, abstract based on the latest piece of documentation within the 24-hour period.**
  
  **Examples:**
  - H&P 0900: “Tachypnea, on 2L NC, chronic emphysema.”
    - Consult 1500: “URI x 2 days with worsening tachypnea.”
      - Elevated respiratory rate should be used.
  - Note 1800: “Patient has been taking Lasix BID for 1 week, presenting with hypotension and dehydration.”
  - Note 2230: “Dehydration and hypotension currently, Lasix discontinued, starting fluid resuscitation for possible sepsis.”
    - Hypotensive readings should be used.

- **SIRS criteria or a sign of organ dysfunction obtained within the operating room (OR) should not be used.**
• SIRS criteria or a sign of organ dysfunction due to artificial interventions should not be used.
  
  **Example:**
  Mechanical ventilator rate set at 24 and respiratory rate is 24, the respiratory rate would not be used for SIRS criteria.

• If an artificial intervention is unable to control a patient’s physiological function, the SIRS criteria or a sign of organ dysfunction should be used.
  
  **Example:**
  Mechanical ventilator rate set at 24 and respiratory rate at 28, the respiratory rate should be used for SIRS criteria.

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

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

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

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

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

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

• If there is more than one presentation of Severe Sepsis in the record, abstract only the first presentation.

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

• If Severe Sepsis is met by physician/APN/PA documentation only, and is documented as due to a viral, fungal, or parasitic infection, the documentation of Severe Sepsis should not be used.
• If clinical criteria for Severe Sepsis are not documented and there is not physician/APN/PA documentation of Severe Sepsis, but there is physician/APN/PA documentation of Septic Shock, choose Value “1.”

• Disregard any documentation of SIRS criteria, organ dysfunction, an infection, Severe Sepsis, or Septic Shock in a discharge note, discharge summary, or documented after the time of discharge.

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

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

<table>
<thead>
<tr>
<th>Positive Qualifiers</th>
<th>Negative Qualifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible</td>
<td>Impending</td>
</tr>
<tr>
<td>Rule out (r/o)</td>
<td>Unlikely</td>
</tr>
<tr>
<td>Suspected</td>
<td>Doubt</td>
</tr>
<tr>
<td>Likely</td>
<td>Risk for</td>
</tr>
<tr>
<td>Probable</td>
<td>Ruled out</td>
</tr>
<tr>
<td>Differential</td>
<td>Evolving</td>
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<tr>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td>Suspicious for</td>
<td>Questionable</td>
</tr>
<tr>
<td>Concern for</td>
<td></td>
</tr>
</tbody>
</table>

Suggested Data Sources:
• Any physician/APN/PA documentation
• Entire ED record
• Hourly output record
• Intake/Output record
• Laboratory results
• Nurses notes
• Vital signs record or flow sheet

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
- **C. difficile (C-diff)**
- 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
- **Septic**
- 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
Data Element Name: Severe Sepsis Presentation Date

Collected For CMS: SEP-1

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

Suggested Data Collection Question: What was the date on which the last criterion was met to establish the presence of severe sepsis?

Format:
   Length: 10 – MM-DD-YYYY (includes dashes) or UTD
   Type: Date
   Occurs: 1

Allowable Values:
   MM = Month (01-12)
   DD = Day (01-31)
   YYYY = Year (20xx)
   UTD = Unable to Determine

Notes for Abstraction:
- 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 without a specific date or documented using the acronym POA, the following apply:
  - If it is the only documentation of Severe Sepsis or Septic Shock in the note, use the date the note was started or opened.
  - If Severe Sepsis or Septic Shock is documented multiple times within the same note, use the earliest specified date.
- Use the earliest documented arrival date for patients who enter the Emergency Department with the following:
  - Severe sepsis clinical criteria met in pre-hospital records
  - Physician/APN/PA documentation of severe sepsis in pre-hospital records
  - Physician/APN/PA documentation that severe sepsis was present on arrival
- Use the earliest documented date patient arrives to floor or unit for admission for patients who are admitted with the following:
  - Severe sepsis clinical criteria met in pre-hospital records and patient is a direct admit
  - Physician/APN/PA documentation of severe sepsis in pre-hospital records and patient is a direct admit
  - Physician/APN/PA documentation that severe sepsis was present on admission
• 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.

**Suggested Data Sources:**
- Any physician/APN/PA documentation
- Entire ED record
- Hourly output record
- Intake/Output record
- Laboratory results
- Nurses notes
- Vital signs record or flow sheet

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: *Severe Sepsis Presentation Time*

Collected For CMS: SEP-1

Definition: The earliest time at which the final criterion was met to establish the presence of severe sepsis.

Suggested Data Collection Question: What was the time at which the last criterion was met to establish the presence of severe sepsis?

Format:
- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight – 00:00  
  Noon – 12:00
- 5:31 am – 05:31  
  5:31 pm – 17:31
- 11:59 am – 11:59  
  11:59 pm – 23:59

Notes for Abstraction:
- 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, the following apply:
  - If it is the only documentation of Severe Sepsis or Septic Shock in the note, use the time the note was started or opened.
  - If Severe Sepsis or Septic Shock is documented multiple times within the same note, use the earliest specified time.
- Use the earliest documented arrival time for patients who enter the Emergency Department with the following:
  - Severe sepsis clinical criteria met in pre-hospital records
  - Physician/APN/PA documentation of severe sepsis in pre-hospital records
  - Physician/APN/PA documentation that severe sepsis was present on arrival
- Use the earliest documented time patient arrives to floor or unit for admission for patients who are admitted with the following:
Severe sepsis clinical criteria met in pre-hospital records and patient is a direct admit

- Physician/APN/PA documentation of severe sepsis in pre-hospital records and patient is a direct admit
- Physician/APN/PA documentation that severe sepsis was present on admission

- 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.

**Suggested Data Sources:**
- Any physician/APN/PA documentation
- Entire ED record
- Hourly output record
- Intake/Output record
- Laboratory results
- Nurses notes
- Vital signs record or flow sheet

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Sex

Collected For CMS/The Joint Commission: All Records

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What was the patient’s sex on arrival?

Format:
- Length: 1
- Type: Character
- Occurs: 1

Allowable Values:
- M = Male
- F = Female
- U = Unknown

Notes for Abstraction:
- Collect the documented patient’s sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select “Unknown” if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transsexual.
  - Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:
- Consultation notes
- Emergency Department record
- Face sheet
- History and physical
- Nursing admission notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None
Data Element Name: Tobacco Use Status

Collected For The Joint Commission Only: All TOB Measures

Definition: 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. Tobacco use includes all forms of tobacco including cigarettes, smokeless tobacco products, pipe, and cigars. A tobacco use screen should identify the type of tobacco product used, the volume used, and the time frame of use.

Suggested Data Collection Question: What is the patient’s tobacco use status?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1. The patient has during the past 30 days:
   - smoked, on average, 5 or more cigarettes (>=¼ pack) daily, and/or
   - smoked cigars and/or pipes daily.

2. The patient has during the past 30 days:
   - smoked, on average, 4 or less cigarettes (<¼ pack) daily, and/or
   - smoked cigarettes, cigars and/or pipes, but not daily, and/or
   - used smokeless tobacco, regardless of frequency.

3. The patient has not used any forms of tobacco in the past 30 days.

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 end of Day 1) because of cognitive impairment.

Notes for Abstraction:
- 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.

- If there is any conflicting documentation about the patient’s tobacco use status, e.g., RN assessment states patient has not used any tobacco products in the past 30 days prior to admission, but there is also physician documentation in the H & P...
that the patient is a “smoker,” select Value “5” since tobacco use status is unable to be determined.

- Documentation of "nicotine" use is not acceptable to determine tobacco use status. The documentation of "nicotine" use needs to be supported by language showing it was in the form of cigarettes, cigars, pipes and/or smokeless tobacco.
- If there is documentation that the patient has not used any tobacco products during the past 30 days prior to admission, continued assessment for the type, volume and frequency does not need to be performed.
- If there is documentation that the patient has used smokeless tobacco AND has also smoked cigarettes daily on average in a volume of five or more cigarettes (=>¼ pack) per day and/or cigars daily and/or pipes daily during the past 30 days, select Value “1.”
- There is no requirement to capture volume and frequency of use for patients using only smokeless tobacco.
- For the History and Physical (H&P) source, use only the H&P report for the current admission. The H&P may be a dictated report, a handwritten report on an H&P form, or a separate entry labeled as the H&P in the progress notes.
- Classify a form as a nursing admission assessment if the content is typical of nursing admission assessment (e.g., med/surg/social history, current meds, allergies, physical assessment) AND the form is completed/reviewed by a nurse or labeled as a “nursing form.”
- Disregard documentation of tobacco use history if the current tobacco use status or time frame that patient quit is not defined (e.g., “20 pk/yr smoking history,” “History of tobacco abuse”).
- Do not include documentation of smoking history referenced as a “risk factor” (e.g., “risk factor: tobacco,” “risk factor: smoking,” “risk factor: smoker”), where current tobacco use status is indeterminable.
- When there is conflicting information in the record with regard to volume, for instance, one document indicates patient is a light smoker and another indicates patient is a volume greater than light smoking; select Value “1” indicating the heaviest usage.
- If the medical record indicates the patient smokes cigarettes and the volume is not documented or is unknown, assume smoking at the heaviest level and select Value “1.”
- 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 end of Day 1).
- If there is documentation within the first day of admission (by end of Day 1) that the patient was psychotic, symptoms of psychosis, e.g., hallucinating, non-communicative, catatonic, etc., must also be documented for the patient to be considered cognitively impaired.
- If there is documentation to “rule out” a condition/diagnosis related to cognitive impairment, Value “6” cannot be selected unless there is documentation of symptoms.

**Examples:**

- Patient actively hallucinating, rule out psychosis. (Select Value “6”).
• Rule out psychosis. (Cannot select Value “6”).

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

• Documentation of cognitive impairment overrides documentation of a tobacco screen and therefore would not be considered "conflicting documentation." Even if the family or others tell staff the patient uses tobacco, the patient could not be appropriately screened and subsequently counseled due to cognitive impairment. Select Value “6.”

**Suggested Data Sources:**

• Emergency Department record
• History and physical
• Nursing admission assessment
• Nursing admission notes
• Physician progress notes
• Respiratory therapy notes

**Inclusion Guidelines for Abstraction:**

• Chewing (spit) tobacco
• Dry snuff
• Moist snuff
• Plug tobacco
• Redman
• Smokeless tobacco
• Snus
• Twist

**Exclusion Guidelines for Abstraction:**

• E-cigarettes
• Hookah pipe
• Marijuana use only
• Nicotine delivery system
• Vaping or nicotine vaporizer use
**Data Element Name:** Tobacco Use Treatment FDA – Approved Cessation Medication

**Collected For The Joint Commission Only:** TOB-2

**Definition:** The FDA-approved tobacco cessation medications may be referenced in Appendix C on Table 9.1.

**Suggested Data Collection Question:** Did the patient receive one of the FDA-approved tobacco cessation medications during the hospital stay?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
1. The patient received one of the FDA-approved tobacco cessation medications during the hospital stay.
2. The patient refused the FDA-approved tobacco cessation medications during the hospital stay.
3. FDA-approved tobacco cessation medications were not offered to the patient during the hospital stay or unable to determine from medical record documentation.

**Notes for Abstraction:**
If nicotine replacement therapy (NRT) is ordered PRN and the patient does not receive any doses during the hospital stay, select Value “2” (the patient refused the FDA-approved tobacco cessation medications during the hospital stay).

**Suggested Data Sources:**
- Medication administration record (MAR)
- Physician orders

**Inclusion Guidelines for Abstraction:**
Refer to Appendix C, Table 9.1 for the list of FDA-approved tobacco cessation medications

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: *Tobacco Use Treatment Practical Counseling*

Collected For The Joint Commission Only: TOB-2

Definition: Practical counseling requires a one-on-one interaction with the patient to address at a minimum the following three components: recognizing danger situations, developing coping skills, and providing basic information about quitting.

Suggested Data Collection Question: Did the patient receive all of the components of practical counseling during the hospital stay?

Format:
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

Allowable Values:
1. The patient received all components of practical counseling during the hospital stay.
2. The patient refused/declined practical counseling during the hospital stay.
3. Practical counseling was not offered to the patient during the hospital stay or unable to determine if tobacco use treatment was provided from medical record documentation.

Notes for Abstraction:
- A referral to the Quitline may be considered a component of practical counseling (providing basic information about quitting), however, handing the patient a phone number to call for the quit line will not meet the intent of practical counseling. There must be interaction between the patient and the caregiver.
- A pamphlet with basic information about quitting, recognizing danger situations and how to develop coping skills may be given to the patient; however, the caregiver must still document what was discussed with the patient from the pamphlet. Giving the patient a pamphlet alone does not constitute practical counseling which requires a one-on-one interaction with the patient.
- Danger situations covered in practical counseling might include alcohol use during the first month after quitting, being around smoke and/or other smokers, or times/situations when the patient routinely smoked (in the car, on break at work, with coffee, after a meal, upon waking up, social events, etc.). Triggers and/or roadblocks are the same as danger situations.
- Coping skills covered in practical counseling might include learning new ways to manage stress, exercising, relaxation breathing, changing routines and distraction techniques to prevent tobacco use.
- Basic information on quitting covered in practical counseling might include the benefits of quitting tobacco, how to quit techniques and available resources to support quitting.
• If there is no documentation that practical counseling was given to the patient, select Value “3.”
• Select Value “3” if the documentation provided is not explicit enough to determine if the counseling provided contained all components or if the counseling meets the intent of the measure.

Suggested Data Sources:
• Medication administration record (MAR)
• Nursing notes
• Physician progress notes
• Respiratory therapy notes

Inclusion Guidelines for Abstraction:
Referral to Quitline

Exclusion Guidelines for Abstraction:
None
Data Element Name: Transfer From Another Hospital or ASC

Collected For CMS Only: SEP-1

Definition: Documentation that the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center (ASC).

Suggested Data Collection Question: Was the patient received as a transfer from an inpatient, outpatient or emergency/observation department of an outside hospital or from an ambulatory surgery center?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) Patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center.
- N (No) Patient was not received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, or unable to determine from medical record documentation.

Notes for Abstraction:
- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “Yes.” This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “Yes.” This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record.
- Select “Yes” in the following types of transfers:
  - Long term acute care (LTAC): Any LTAC hospital or unit (outside or inside your hospital)
  - Acute rehabilitation: Rehab unit in outside hospital, free-standing rehab hospital/facility/pavilion outside your hospital, OR rehab hospital inside your hospital
  - Psychiatric: Psych unit in outside hospital, free-standing psych hospital/facility/pavilion outside your hospital, OR psych hospital inside your hospital
  - Cath lab, same day surgery, or other outpatient department of an outside hospital
• Disaster Medical Assistance Team (DMAT): Provides emergency medical assistance following catastrophic disaster or other major emergency

• Select “No” in the following types of transfers:
  o Urgent care center
  o Psych or rehab unit inside your hospital
  o Dialysis center (unless documented as an outpatient department of an outside hospital)
  o Same Day Surgery or other outpatient department inside your hospital
  o Clinic (outside or inside your hospital)
  o Hospice facility (outside or inside your hospital)
  o Assisted living facilities and nursing homes
  o Skilled nursing facility (SNF) care: Any facility or unit (outside or inside your hospital) providing SNF level of care to patient

• If there is conflicting documentation in the record, and you are unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, select “No” UNLESS there is supporting documentation for one setting over the other.

Examples:
  o One source reports patient was transferred from an outside hospital’s ED, another source reports patient was transferred in from an urgent care center. No additional documentation. Select “No.”
  o One source states patient came from physician office, another source reports patient was transferred from an outside hospital’s ED, and transfer records from the outside hospital’s ED are included in the record. Select “Yes.”

• If, in cases other than conflicting documentation, you are unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, select “No.” (e.g., “Transferred from Park Meadows” documented – documentation is not clear whether Park Meadows is a hospital or not.)

Suggested Data Sources:
• Ambulance record
• Any DMAT documentation
• Emergency Department record
• Face sheet
• History and physical
• Nursing admission assessment
• Progress notes
• Transfer sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Vasopressor Administration

Collected For CMS: SEP-1

Definition: Documentation of administration of an intravenous or intraosseous vasopressor in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration.

Suggested Data Collection Question: Was an intravenous or intraosseous vasopressor administered in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1 (Yes) The patient was given an intravenous or intraosseous vasopressor in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock.

2 (No) The patient was not given an intravenous or intraosseous vasopressor in the time window beginning at septic shock presentation and ending 6 hours after the time of presentation of septic shock.

Notes for Abstraction:
- The list of acceptable vasopressors is contained in Appendix C, Table 5.2. These are the only medications that can be abstracted.
- Only abstract a vasopressor given via the IV or intraosseous (IO) route.
- Vasopressor administration information should only be abstracted from documentation that demonstrates actual administration of the vasopressor.
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
  - Acceptable examples of administration include: “vasopressor running” and “vasopressor given.”
- If a vasopressor was infusing at the time of presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration, choose Value “1.” For example, septic shock patient was triaged in the ED at 08:00. The patient was receiving Levophed via an IV at the time of triage – choose Value “1.”
- If a vasopressor was not started or running within the acceptable time frame, select Value “2.”
A dose can be abstracted that is given by one person and documented as being given by another person if that dose is not documented by the person that actually administered it.

Authentication on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.

The method of designation of administration on hand-written or pre-printed forms, such as MARs or eMARs, must be clearly designated as given. The methods may vary. Whatever method is used, it must be clear that the dose was administered.

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

Do not abstract test doses of vasopressors.

Do not abstract vasopressors from narrative charting unless there is no other documentation that reflects that the same vasopressor was given during the specified time frame.

**Suggested Data Sources:**
- Entire Emergency Department record
- IV flow sheets
- Medication Administration record (MAR)
- Nursing notes
- Physician/APN/PA notes
- Transport records

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: *Vasopressor Administration Date*

Collected For CMS: SEP-1

Definition: The date on which an intravenous or intraosseous vasopressor was administered within 6 hours following the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration.

Suggested Data Collection Question: What was the date on which an intravenous or intraosseous vasopressor was administered within 6 hours following the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration?

Format:
- **Length:** 10 – MM-DD-YYYY (includes dashes) or UTD
- **Type:** Date
- **Occurs:** 1

Allowable Values:
- **MM = Month (01-12)**
- **DD = Day (01-31)**
- **YYYY = Year (20xx)**
- **UTD = Unable to Determine**

Notes for Abstraction:
- The list of acceptable vasopressors is contained in Appendix C, Table 5.2. These are the only medications that can be abstracted.
- Only abstract a vasopressor given via the IV or intraosseous (IO) route.
- Vasopressor administration information should only be abstracted from documentation that demonstrates actual administration of the vasopressor.
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
  - Acceptable examples of administration include: “vasopressor running” and “vasopressor given.”
- If a vasopressor was infusing at the time of presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration, or the vasopressor was infusing at the time of septic shock and multiple doses were subsequently given, abstract the date the vasopressor that was infusing at the time of presentation of septic shock was initiated.
  - **Example:**
    Septic shock patient was triaged in the ED at 08:00. At the time of triage, the patient was receiving Levophed via an IV started prior to arrival, abstract the date the Levophed was started prior to arrival.
- If the patient received multiple doses of a vasopressor and there was no vasopressor infusing at the time of presentation of septic shock, abstract the dose given closest to the time of presentation of septic shock.
• A dose can be abstracted that is given by one person and documented as being
given by another person if that dose is not documented by the person that actually
administered it.
• Only abstract from an undated MAR if it has a patient sticker on it and it is titled
first day or initial MAR. If an undated MAR is designated as the initial or first day
MAR and it does not have a patient sticker on it, use UTD for the date.
• Authentication on one side/page of a multi-side or multi-page form applies to all
pages of the form. The sides/pages of the form must be identifiable as being from
the same form.
• The method of designation of administration on hand-written such as MARs or
eMARs, must be clearly designated as given. The methods may vary. Whatever
method is used, it must be clear that the dose was administered.
• Use of documentation in pre-hospital records (e.g., ambulance records, nursing
home records) that are considered part of the medical record is acceptable.
• Do not abstract test doses of vasopressors.
• Do not abstract vasopressors from sources that do not represent actual
administration.
• Do not abstract vasopressors from narrative charting unless there is no other
documentation that reflects that the same vasopressor was given during the
specified time frame.

Suggested Data Sources:
• Entire Emergency Department record
• IV flow sheets
• Medication Administration record (MAR)
• Nursing notes
• Physician/APN/PA notes
• Transport records

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Vasopressor Administration Time

Collected For CMS: SEP-1

Definition: The time at which an intravenous or intraosseous vasopressor was administered within 6 hours following the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration.

Suggested Data Collection Question: What was the time at which an intravenous or intraosseous vasopressor was administered within 6 hours following the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration?

Format:
- Length: 5 - HH:MM (with or without colon) or UTD
- Type: Time
- Occurs: 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight – 00:00
- Noon – 12:00
- 5:31 am – 05:31
- 5:31 pm – 17:31
- 11:59 am – 11:59
- 11:59 pm – 23:59

Notes for Abstraction:
- The list of acceptable vasopressors is contained in Appendix C, Table 5.2. These are the only medications that can be abstracted.
- Only abstract a vasopressor given via the IV or intraosseous (IO) route.
- Vasopressor administration information should only be abstracted from documentation that demonstrates actual administration of the vasopressor.
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
  - Acceptable examples of administration include: “vasopressor running” and “vasopressor given.”
- If a vasopressor was infusing at the time of presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration, or the vasopressor was infusing at the time of septic shock and multiple doses were subsequently given, abstract the time the vasopressor that was infusing at the time of presentation of septic shock was initiated.
**Example:**
Septic shock patient was triaged in the ED at 08:00. At the time of triage, the patient was receiving Levophed via an IV started prior to arrival at 07:45, abstract the time the Levophed was started prior to arrival, 07:45.

- If the patient received multiple doses of a vasopressor and there was no vasopressor infusing at the time of presentation of septic shock, abstract the dose given closest to the time of presentation of septic shock.
- A dose can be abstracted that is given by one person and documented as being given by another person if that dose is not documented by the person that actually administered it.
- Only abstract from an undated MAR if it has a patient sticker on it and it is titled first day or initial MAR. If an undated MAR is designated as the initial or first day MAR and it does not have a patient sticker on it, use UTD for the time.
- Authentication on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.
- The method of designation of administration on hand-written such as MARs or eMARs, must be clearly designated as given. The methods may vary. Whatever method is used, it must be clear that the dose was administered.
- Use of documentation in pre-hospital records (e.g., ambulance records, nursing home records) that are considered part of the medical record is acceptable.
- Do not abstract test doses of vasopressors.
- Do not abstract vasopressors from narrative charting unless there is no other documentation that reflects that the same vasopressor was given during the specified time frame.

**Suggested Data Sources:**
- Entire Emergency Department record
- IV flow sheets
- Medication Administration record (MAR)
- Nursing notes
- Physician/APN/PA notes
- Transport records

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: VTE Confirmed

Collected For The Joint Commission Only: VTE-6

Definition: Documentation by a physician/APN/PA that a diagnosis of new/acute VTE [deep vein thrombosis (DVT) and/or pulmonary embolism (PE)] was confirmed in a defined location on the day of arrival or anytime during the hospitalization.

Suggested Data Collection Question: Is there physician/APN/PA documentation that a new/acute VTE was confirmed in one of the defined locations on the day of arrival or anytime during the hospitalization?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) There is physician/APN/PA documentation that a new/acute VTE was confirmed in one of the defined locations on the day of arrival or anytime during the hospitalization.
- N (No) There is no physician/APN/PA documentation that a new/acute VTE was confirmed in one of the defined locations on the day of arrival or anytime during the hospitalization, or unable to determine from medical record documentation.

Notes for Abstraction:
- If the patient had a new or acute VTE in one of the defined locations which was confirmed by a physician/APN/PA following an acceptable VTE Diagnostic Test, select “Yes.” Refer to the data element VTE Diagnostic Test for a list of acceptable tests.

Examples:
  - Physician/APN/PA documentation states that PE was confirmed with a VQ scan on Day 4 of the hospital stay, select “Yes.”
  - Physician/APN/PA documentation states that the patient arrived without prior DVT confirmation, but two days after admission, there is documentation based on a venous Doppler that the patient has an acute right popliteal DVT, select “Yes.”
  - Physician/APN/PA documentation states that a CT abdomen with IV contrast was done during the hospital stay and noted an extensive IVC thrombus, select “Yes.”
  - Physician/APN/PA documentation states that the patient had a MRI of the lower extremity leg veins which confirmed the development of the VTE during the hospital stay without mention of the VTE location, select “No.”

- If the patient was transferred from another acute care hospital with a VTE, and there is no documentation indicating the VTE location, select “No.”
- Physician/APN/PA documentation of VTE described as either occlusive or non-occlusive is acceptable.
• In cases where VTE is documented in a defined location, consider it a new or acute VTE unless described as otherwise, e.g., chronic. The terms “new” or “acute” do not need to be explicitly documented to select “Yes.”

• Recurrent, chronic, sub-acute, indeterminate age, or history of VTE, select “No.”

  **Example:**
  Venous Doppler is performed on the day of admission. The results document DVT in the right popliteal vein which appears to be chronic. MD note states “no calf tenderness or swelling.” No other documentation of a new or acute VTE in the medical record, select “No.”

  **EXCEPTION:**
  Documentation of an acute or new VTE in a defined location is also present in the medical record.

  **Example:**
  If a patient had a history of lower extremity DVT, but vascular ultrasound done after hospital admission found a new DVT in the popliteal vein of the right lower extremity, select “Yes.”

• If more than one acceptable VTE Diagnostic Test was performed, review the chart for the earliest acceptable VTE Diagnostic Test that confirmed the VTE in one of the defined locations.

  **Example:**
  Patient had CT of chest with contrast in the emergency department on 02/01/20xx for shortness of breath, no PE confirmed. The patient was admitted on 02/02/20XX. The patient had venous ultrasound with confirmed proximal left common iliac DVT on 02/04/20XX. Select “Yes.”

• If conflicting documentation between providers is present, select “Yes.”

  **Example:**
  PCP documents acute deep femoral DVT but oncologist states that DVT appears to be chronic.

• For patients with radiology reports that state “low probability” or “inconclusive test results” on any of the acceptable VTE Diagnostic Tests, select “No.”

• For patients with a nuclear medicine VQ scan to rule-out PE; if the result was documented as “high probability,” select “Yes.” For all other impressions (e.g., “low probability,” “intermediate,” “intermediate to high probability” or “inconclusive test results”), select “No.”

• If there is questionable physician/APN/PA documentation regarding whether the patient had VTE, select “Yes.”

  **Example:**
  If the radiologist interpretation of the exam did not confirm DVT, but there is documentation of a DVT in physician’s progress notes, select “Yes.”

• If there is physician/APN/PA documentation that the patient had a VTE, select “Yes.”

• If the record indicates ONLY a radiology report, and that report is questionable regarding whether the patient had a VTE, select “No.”

  **Examples:**
  o If the radiology report of a CTA indicates, “possible” or “suggestive of” common femoral clot, select “No.”
  o If the radiology report of an angiogram indicates, distal vein clot that may extend into the greater saphenous vein, select “No.”
Documentation in sources other than radiology reports:

- The physician/APN/PA documentation must indicate the clinician’s confirmation of an acute VTE in a defined location.
  
  **Examples:**
  - Physician Notes: Venous Doppler on day of admission positive for DVT left popliteal vein clot, select “Yes.”
  - Emergency Notes: Venogram positive for VTE, select “No.”

- The physician/APN/PA documentation must reflect the time frame from arrival to hospital discharge.

Suggested Data Sources:
**PHYSICIAN/APN/PA DOCUMENTATION ONLY**

- Admission notes
- Consult notes
- Emergency Department record
- History and physical
- Physician notes
- Radiology report

**Inclusion Guidelines for Abstraction:**

**THIS LIST IS ALL INCLUSIVE**

**VTE Location**

*VTE Confirmed* is defined as:

Pulmonary Emboli (PE), pulmonary artery embolism, pulmonary trunk embolism, saddle embolism

Or

DVT Located in:

- Common femoral vein
- Common Iliac
- External Iliac vein
- Femoral/superficial femoral vein
- Inferior vena cava (IVC)
- Intrahepatic IVC
- Internal iliac
- Popliteal vein
- Profunda / deep femoral vein
- Saphenofemoral junction WITH extension into the common femoral vein
- Tumor thrombus in the IVC or another defined location

**Exclusion Guidelines for Abstraction:**

**Patients with VTE in the following areas:**

- Confirmed sites of venous thrombosis without a proximal leg DVT or PE also involved.
- History of VTE without documentation of a new/acute event
- Not in the defined locations
- Anterior tibial vein
- Cerebral venous thrombosis (CVT)
- Gastrocnemius vein
- Hepatic/portal/splenic/mesenteric thrombosis
- Ovarian vein thrombosis
- Peroneal vein
- Posterior tibial vein
- Renal vein thrombosis
- Saphenofemoral junction
- Saphenofemoral junction WITHOUT extension into the common femoral vein
- Septic emboli
- Soleal vein
- Stroke / ischemic stroke
- Thrombus in the heart
- Upper extremity thrombosis
Data Element Name: VTE Diagnostic Test

Collected For The Joint Commission Only: VTE-6

Definition: Documentation that a diagnostic test was performed during the hospitalization.

Suggested Data Collection Question: Is there documentation that a diagnostic test was performed on the day of arrival or anytime during the hospitalization?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) There is documentation that a diagnostic test was performed on the day of arrival or anytime during the hospitalization.
- N (No) There is no documentation that a diagnostic test was performed on the day of arrival or anytime during the hospitalization, or unable to determine from medical record documentation.

Notes for Abstraction:
- The time frame for this data element includes patients who had one of the acceptable diagnostic tests performed on arrival or anytime during hospitalization.  
  
  Acceptable Examples:
  - Patient arrives on 01/01/20XX and documentation indicates a CT of chest with contrast was performed earlier that same day.
  - Patient arrived on 01/01/20XX and documentation indicates that the patient was admitted on 01/02/20XX. A VQ scan was performed on 01/04/20XX.

  Unacceptable Example:
  - Patient transferred on 01/05/20XX with documentation from a transferring hospital indicating vascular ultrasound was performed on 01/02/20XX.

- If a diagnostic test was performed that is not on the inclusion list, select “No.”
  
  Example:
  Patient admitted on 01/01/20XX. 2D Echo done on 01/05/20XX. Physician notes indicate that the test confirmed a PE, select “No.”

Documentation in sources other than radiology reports:
- Documentation other than radiology reports must confirm one of the acceptable tests was performed.

  Examples:
  - Physician Notes: Venous Doppler positive for DVT left popliteal, select “Yes.”
  - Emergency Notes: Patient to CT without contrast, select “No.”
• The physician/APN/PA documentation must reflect the time frame from arrival to hospital discharge.

**Suggested Data Sources:**
- Admission notes
- Consult notes
- Emergency Department record
- History and physical
- Physician notes
- Radiology report

**Inclusion Guidelines for Abstraction:**
**Diagnostic testing includes the following:**
**THIS LIST IS ALL INCLUSIVE**
- Compression Ultrasound of lower extremities
- Vascular Ultrasound of lower extremities
- Duplex Ultrasound (DUS) of lower extremities
- Venous Doppler of lower extremities
- Vascular vein mapping of the lower extremities
- Computed tomography angiography (CTA) / Angiogram of Chest
- Computed tomography angiography (CTA) / Pulmonary Angiogram of Chest
- Computed tomography (CT) of thorax (chest) with IV contrast
- Computed tomography angiography (CTA) / Angiogram of the abdomen
- Computed tomography (CT) of the abdomen/abdominal aorta with IV contrast
- Computed tomography (CT) of the pelvis with IV contrast
- Computed tomography angiography (CTA) / Angiogram of the pelvis
- Computed tomography (CT) of the lower extremity leg veins with IV contrast
- Magnetic resonance imaging (MRI or MRV) of the thorax (chest, cardiac)
- Magnetic resonance imaging (MRI or MRV) of the abdomen
- Magnetic resonance imaging (MRI or MRV) of the pelvis
- Magnetic resonance imaging (MRI or MRV) of the lower extremity leg veins
- Nuclear Medicine Pulmonary Scan/ventilation/perfusion (V/Q) lung scan
- Pulmonary arteriography/angiography/angiogram
- Cavagram/cavogram
- Inferior venocavagram
- Venography/Venogram of pelvis using IV contrast material
- Venography/Venogram of femoral using IV contrast material
- Venography/Venogram of other lower extremity veins using IV contrast material

**Exclusion Guidelines for Abstraction:**
- Patients with VTE confirmation by only D-dimer tests
- Patients with VTE diagnosed by tests not listed
Data Element Name: VTE Present at Admission

Collected For The Joint Commission Only: VTE-6

Definition: Documentation by a physician/APN/PA that VTE was diagnosed or suspected on arrival to the day after admission.

Suggested Data Collection Question: Was there any documentation by the physician/APN/PA that VTE was diagnosed or suspected on arrival to the day after admission?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) There is documentation by the physician/APN/PA that VTE was diagnosed or suspected from hospital arrival to the day after admission.
- N (No) There is no documentation by the physician/APN/PA that VTE was diagnosed or suspected from hospital arrival to the day after admission or unable to determine from medical record documentation.

Notes for Abstraction:
- The time frame for this data element includes any documentation dated from hospital arrival to the day after admission. It is not necessary to review documentation outside of this time frame to answer this data element.
- Documentation of suspicion or a diagnosis of a pulmonary embolism (PE) or venous thromboembolism (VTE) in a confirmed location is acceptable. Only accept terms identified in the list of inclusions.

Acceptable Examples:
- A patient arrived on 10/1/20xx with shortness of breath. On 10/2/20XX, there is physician documentation that a PE is suspected, select “Yes.”
- Results of a venous Doppler performed the day after admission are positive for VTE in the common femoral vein, select “Yes.”
- Day of admission physician includes PE on the problem list, select “Yes.”
- Patient admitted with a diagnosis of left popliteal deep vein thrombus, select “Yes.”
- Patient arrived on 01/05/20XX with documentation from an outside transferring hospital indicating vascular ultrasound was performed on 01/02/20XX and positive for VTE, select “Yes.”

Unacceptable Examples:
- H&P on day of admission notes that the patient has an occlusion of the subclavian vein. Subclavian vein is not a defined location, select “No.”
• A patient arrives to the hospital emergency department with C/O severe headache. Differential diagnosis on the day of arrival includes cerebral venous thrombosis (CVT) versus SAH, select “No.”
• Physician admitting note documents DVT prophylaxis under the treatment plan, select “No.”
• Patient admitted with a diagnosis of left upper extremity deep vein thrombus, select “No.”
• Patient has a CT chest with IV contrast on the day of arrival to R/O PE and test results are negative and received by 2359 the day after admission, select “No.”

• An order for a VTE diagnostic test is acceptable ONLY if it is explicitly documented that VTE/PE is the reason for the test. Only accept terms identified in the list of inclusions.

  Acceptable Examples:
  o A patient presents to the hospital emergency department with a chief complaint of pain and swelling in the right calf. A vascular ultrasound of the lower extremities is ordered to R/O DVT, select “Yes” UNLESS results are negative and received by 2359 the day after admission.
  o A patient arrives on 06/01/20XX. Admitting diagnosis is fever. On 06/02/20XX patient admitted and physician documents “if cough continues may require evaluation for PE.” On 06/03/20XX, CTA chest is ordered and completed. Select “Yes.”

  Unacceptable Examples:
  o Physician orders a bilateral lower extremity arterial duplex on the day after admission. Arterial duplex is not an acceptable test. Select "No" for VTE Present on Admission.
  o Patient presents to the emergency room with complaints of pain all over after sustaining a fall. ED MD orders multiple tests including a CT of the chest with IV contrast. ED MD documents fall as the reason for the test. No mention of PE/VTE, select “No.”
  o A patient is admitted after a motor vehicle accident. On arrival, a CT of the abd/pelvis with IV contrast was done to R/O internal injuries. No mention of PE/VTE, select “No.”

• Patients who are under treatment and receiving anticoagulation therapy for PE/VTE at the time of hospital arrival, select “Yes.”
  Example:
  o Patient admitted 04/30/20XX. Physician documents on 04/30/20XX that Coumadin was started on 04/20/20XX for a recently diagnosed PE, select “Yes.”

• Patients on anticoagulation therapy for another condition (e.g., atrial fibrillation, mitral valve replacement) at the time of hospital arrival, select “Yes.”
  Examples:
  o Patient with a history of stroke and taking dabigatran as a home medication prior to arrival, select “YES.”
  o H&P documents chronic VTE. Taking Coumadin, select “Yes.”

• For patients with only a past history of VTE documented, select “No.”
  Example:
  o Problem list includes PE 199X, select “No.”
If the patient was admitted and had surgery on day of or day after hospital admission or ICU admission and there was no documentation of diagnosed/suspected VTE prior to surgery, the VTE is **not** considered present on admission. Select “No.”

**Suggested Data Sources:**
**PHYSICIAN/APN/PA DOCUMENTATION ONLY**
- Consultation notes
- Emergency Department record
- History and physical
- Radiology report
- Observation notes
- Outpatient surgery notes
- Physician notes

**Inclusion Guidelines for Abstraction:**
**VTE Confirmed** is defined as:
Pulmonary Emboli (PE), pulmonary artery embolism, pulmonary trunk embolism, saddle embolism
Or
DVT Located in:
- Common femoral vein
- Common Iliac
- External Iliac vein
- Femoral/superficial femoral vein
- Inferior vena cava (IVC)
- Intrahepatic IVC
- Internal iliac
- Popliteal vein
- Profunda / deep femoral vein
- Saphenofemoral junction WITH extension into the common femoral vein
- Tumor thrombus in the IVC or another defined location

**VTE Diagnostic Test:**
**THIS LIST IS ALL INCLUSIVE**
- Compression Ultrasound of lower extremities
- Vascular Ultrasound of lower extremities
- Duplex Ultrasound (DUS) of lower extremities
- Venous Doppler of lower extremities
- Vascular vein mapping of the lower extremities
- Computed tomography angiography (CTA) / Angiogram of Chest
- Computed tomography angiography (CTA) / Pulmonary Angiogram of Chest
- Computed tomography (CT) of thorax (chest) with IV contrast
- Computed tomography angiography (CTA) / Angiogram of the abdomen
- Computed tomography (CT) of the abdomen/abdominal aorta with IV contrast
- Computed tomography (CT) of the pelvis with IV contrast
- Computed tomography angiography (CTA) / Angiogram of the pelvis
• Computed tomography (CT) of the lower extremity leg veins with IV contrast
• Magnetic resonance imaging (MRI or MRV) of the thorax (chest, cardiac
• Magnetic resonance imaging (MRI or MRV) of the abdomen
• Magnetic resonance imaging (MRI or MRV) of the pelvis
• Magnetic resonance imaging (MRI or MRV) of the lower extremity leg veins
• Nuclear Medicine Pulmonary Scan/ventilation/perfusion (V/Q) lung scan
• Pulmonary arteriography/angiography/angiogram
• Cavagram/cavogram
• Inferior venocavagram
• Venography/Venogram of pelvis using IV contrast material
• Venography/Venogram of femoral using IV contrast material
• Venography/Venogram of other lower extremity veins using IV contrast material

Exclusion Guidelines for Abstraction:

**VTE Confirmed:**
• History of PE or VTE without documentation of a new/acute event
• VTE not in a defined location

**VTE Diagnostic Test:**
• Patients with PE or VTE diagnosed by tests not listed
**Data Element Name:** VTE Prophylaxis Status

**Collected For The Joint Commission Only:** VTE-6

**Definition:** Documentation of VTE prophylaxis (mechanical or pharmacologic) administration between the hospital arrival date and the day before the VTE Diagnostic Test order date.

**Suggested Data Collection Question:** Was VTE prophylaxis administered between the arrival date and the day before the VTE Diagnostic Test order date?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **Y (Yes)** There is documentation that VTE prophylaxis was administered between the day of arrival and the day before the VTE Diagnostic Test order date.
- **N (No)** There is no documentation that VTE prophylaxis was administered between the day of arrival and the day before the VTE Diagnostic Test order date or unable to determine from medical record documentation.

**Notes for Abstraction:**
- If ANY VTE prophylaxis was administered within the specified time frame above, select “Yes.”
- If more than one acceptable VTE Diagnostic Test was ordered to rule out VTE and both confirmed VTE, select the earliest diagnostic test ordered that confirmed VTE to determine if the patient received VTE prophylaxis.
  - **Example:**
    Patient arrived on 11/1/20XX. A venous Doppler of lower extremities was ordered 11/4/20xx and confirmed a DVT of the right lower extremity. In addition, a CT scan with contrast was ordered on 11/5/20xx and confirmed a PE. Determine if any prophylaxis was administered any time between the hospital arrival date of 11/1/20XX and 11/3/20xx. If no prophylaxis was given, select “No.”
- If the VTE Diagnostic Test was ordered the day of or the day after the arrival date, select “Yes.”
- If the record contains questionable information regarding the administration of VTE prophylaxis the day before the VTE Diagnostic Test was ordered, select “No.”
- Application of mechanical prophylaxis may be documented by any personnel.
  - **Example:**
    Nursing assistant documentation of IPC application during the allowable time frame is acceptable.
• Evaluate prophylaxis with documentation of administration only.
  
  **Example:**
  The only documentation of prophylaxis is in the physician progress notes under assessment/Plan: “DVT prophylaxis – IPC,” select “No” because there is no documentation of administration.

• If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), select “Yes” if the substitution medication was administered.
  
  **Note:** No copy of the formulary or protocol is required in the medical record.
  
  **Example:**
  Lovenox is ordered but not administered, and is substituted with Arixtra, which is administered. Select “Yes.”

• Aspirin is only acceptable as VTE prophylaxis in total hip replacement and total knee replacement surgery.

**Suggested Data Sources:**
- Circulator notes
- Emergency department record
- Graphic/flow sheets
- Medication administration record
- Nursing notes
- Operative notes
- Physician notes
- Preoperative nursing notes
- Progress notes
- Radiology reports

**Inclusion Guidelines for Abstraction:**
A list of the ONLY acceptable diagnostic tests is found in the data element **VTE Diagnostic Test.**

Refer to Appendix H, Table 2.1 VTE Prophylaxis Inclusion Table.

**Exclusion Guidelines for Abstraction:**
None
Missing and Invalid Data

Introduction

Missing data refers to data elements, required for calculating a national hospital quality measure, that have no values present for one or more episodes of care (EOC) records. Invalid data refers to data element values, required for calculating a national hospital quality measure, that fall outside of the range of allowable values defined by The Joint Commission and Centers for Medicare & Medicaid Services (CMS) for that data element.

Reducing missing and invalid data minimizes the bias to a measure rate, because episodes of care with missing or invalid data cannot be included in the calculation of the observed measure rate. A measure’s observed rate may not accurately reflect the patient population, if the excluded EOC records differ significantly from the EOCs with no missing data that were included in the measure calculation.

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

Abstractors must ‘touch’ and provide an answer to every data element that is applicable per the combined skip logic of all of the measures in a topic. While there is an expectation that all data elements are collected, it is recognized that in certain situations information may not be available (dates, times, codes, etc.). If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select “Unable to Determine (UTD)” as the answer. The “UTD” allowable value is used as follows:

- **Admission Date, Birthdate, Discharge Date, ICD-10-CM Principal and Other Diagnosis Codes, and ICD-10-PCS Principal and Other Procedure Codes** do not have an “UTD” allowable value for transmission to CMS and The Joint Commission. EOC records containing “UTD” for any of these data elements are rejected when submitted to the CMS Clinical Warehouse and the Joint Commission’s Data Warehouse.

- Date, time, and numeric data elements, other than Admission Date, Birthdate, and Discharge Date, have an “UTD” allowable value option.
  - Rate-based algorithms evaluate EOC records to a Measure Category Assignment equals “D” (failed) when a date, time, or numeric data element containing an allowable value of “UTD” is evaluated.
  - Continuous variable algorithms evaluate EOC records to a Measure Category Assignment equals “Y” (UTD value exists) when a date, time, or numeric data element containing an allowable value of “UTD” is evaluated.
  - The method by which data collection software collects “UTD” information is determined by each software vendor; except the software cannot automatically default an “UTD” answer. The decision to enter an “UTD” for each data element is up to the abstractor, not the software.
  - There are specific requirements pertaining to the transmission of this value. Refer to the Transmission section in this manual for more information.
Yes/No data elements: The allowable value “No” incorporates “UTD” into the definition. Refer to the measure algorithms in which each Yes/No data element is used to determine how the EOC record is treated.

Data elements containing two or more categorical values: The “UTD” value is either classified as a separate allowable value (e.g., *Blood Culture Collection Date*) or included in the same category as “Not documented or UTD” (e.g., *Discharge Disposition*). Refer to the measure algorithms in which each categorical data element is used to determine how the EOC record is treated.

Missing and Invalid Episode of Care (EOC) Data

The CMS Clinical Warehouse and the Joint Commission’s Data Warehouse evaluate patient data using the missing, invalid and data integrity edits. Refer to the Feedback Messages documents located on QualityNet for CMS, and on the Upload/Download page in the HCD section on PET for Joint Commission, for a complete listing of all critical and informational edits. Differences in the acceptance and rejection of patient data may occur due to differences in hospitals measure selections with the two organizations and how CMS only and Joint Commission only data elements evaluate. Refer to the Alphabetical Data Element List in the Data Dictionary for information concerning which data elements are CMS or Joint Commission only. **Rejected data must be corrected and resubmitted before the transmission deadline in order for it to be accepted by either warehouse.**

- The majority of general data elements that are missing data* cause the EOC record to be rejected. These data elements include *Admission Date, Birthdate, Discharge Date, ICD-10-CM Principal Diagnosis Codes*. Refer to the Introduction to the Data Dictionary in this manual for the complete list of general data elements.
  - Not all patients have an *ICD-10-CM Other Diagnosis Code* or *an ICD-10-PCS Principal and Other Procedure Codes*. Records will be accepted missing data* for these general data elements.

- Measure-specific data elements that are missing data* cause the EOC record to be rejected if any measure algorithm results in a *Measure Category Assignment* equals “X” (missing data). If no measure evaluates to a category assignment of “X”, the EOC record will be accepted.

- General and measure specific data elements that contain invalid data cause the EOC record to be rejected.

- All cases submitted to the CMS Clinical Warehouse or the Joint Commission Data Warehouse are required to be complete if they have data related to:
  - Procedure Codes

  If the abstractor, after due diligence, is not able to determine an answer, a value of “UTD” may be selected for the applicable data element. This includes:
  - ICD-10-PCS Principal Procedure Codes and ICD-10-PCS Other Procedure Codes require the data element ICD-10-PCS Principal Procedure Date and ICD-10-PCS Other Procedure Date to be submitted with the case. Please see the data element definitions for further details on allowable values. If the case is missing the corresponding allowable answer value, the case will be rejected from the CMS Clinical Warehouse and the Joint Commission Warehouse.
**Abstraction Software Skip Logic and Missing Data**

Skip logic allows hospitals and vendors to minimize abstraction burden by using vendor software edit logic to bypass abstraction of data elements not utilized in the measure algorithm. However, these bypassed elements also negatively impact data quality and the hospital’s CMS chart audit validation results when elements are incorrectly abstracted and subsequent data elements are bypassed and left blank.

The use of skip logic by hospitals and ORYX® Vendors is optional and not required by CMS and The Joint Commission. Hospitals should be aware of the potential impact of skip logic on data quality, abstraction burden, and CMS chart audit validation scores. Vendors and hospitals utilizing skip logic should closely monitor the accuracy rate of abstracted data elements, particularly data elements placed higher in the algorithm flow (e.g., Comfort Measures data element).

Historically, CMS chart audit validation results have been used in previous payment years as one of many requirements in the Hospital Inpatient Quality Reporting Program. Please refer to the Federal Register and the QualityNet website for the current payment year’s proposed and final requirements for acute care Inpatient Prospective Payment System (IPPS) hospitals.

**Missing, Invalid, UTD Data Summary**

- **Missing Data:** No data element value is present (blank or “null”).
- **Invalid Data:** The data element value falls outside of the range of defined allowable values.
- **UTD:** The allowable value of “UTD” is present for the data element.

*Note:* A missing value occurs when the abstractor does not select an answer for a data element (leaves it blank) or the software incorrectly transmits a “null” instead of the correct value for a data element. A “UTD” allowable value is not considered missing data.