# CORE MEASURES Q&A

## REAL-TIME QUESTIONS FROM REAL-LIFE ABSTRACTORS

**Staying up-to-date on the latest core measures specifications, and ensuring that each abstraction is completed correctly to produce timely, accurate, actionable data, can feel extremely daunting. Here are some of the tough questions our abstractors have experienced when working with our clients.**

***Q - Here's a two-part question to help clear up some confusion over the physician's wording of "septic shock." First, if the physician wrote "sepsis with shock," can this be used to abstract septic shock? Second, what if it was written "sepsis and shock?"***

***A*** - Great question. Neither would be considered septic shock. The first example is not specific to "severe sepsis with shock" or "septic shock." The second would not be considered documentation of septic shock.

***Q - This is a question about determining persistent hypotension. The physician ordered 1908ml of fluid for a patient, but based on weight, the patient required 1920ml. Using the 10% allowance, the patient could have 1728ml of fluid to pass the crystalloid fluid element. For hypotension, would the start time of the window begin when the patient received 10% (the minimum required) or the full volume ordered? And if a patient is given more than enough fluids, do we start the time window at the time 10% calculated volume completed OR only use the 10% allowance in the absence of sufficient fluids calculated by weight?***

***A*** - The 10% allowance only applies to the physician's order for fluids. There are three parts to this answer.

- With the patient requiring 1920 ML to equal 30 ML/kg, the physician would need to oder at least 1728 mL and the patient would need to receive the complete order amount of fluids to suffice crystalloid fluid administration.
- If the fluid order was for 1908 mL, the complete 1908 mL would need to be administered to select "Yes" to crystalloid fluid administration.
- If the patient required 1920 mL to equal 30 mL/kg and the physician ordered 2000 mL, 1920 mL would need to be completed.

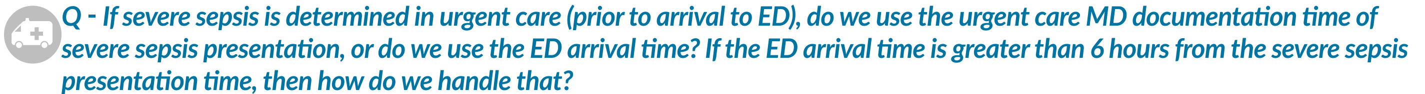
***Q - "COPD acute exacerbation" is noted as a possible infection in the guidelines for abstraction? Is the word "acute" required or is "COPD exacerbation" sufficient?***

***A*** - Since the word "COPD exacerbation" by itself is not listed in the inclusion list for infections, you would have to consult other medical sources to determine if this could be considered an infection or not.

- If a condition documented in the medical record does not include the word "infection," or is not in the Inclusion Guidelines for Abstraction infection list, consulting other medical resources (such as a medical dictionary) to identify whether or not the condition is an infection or is caused by an infection is acceptable.
- If the other medical resource indicates the condition is an infection or is caused by an infection, it may be used to meet the suspected infection criteria.
- If the other medical resource indicates the condition is NOT an infection and NOT caused by an infection, it may NOT be used to meet the suspected infection criteria.
- If the other medical resource indicates the condition may be 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.

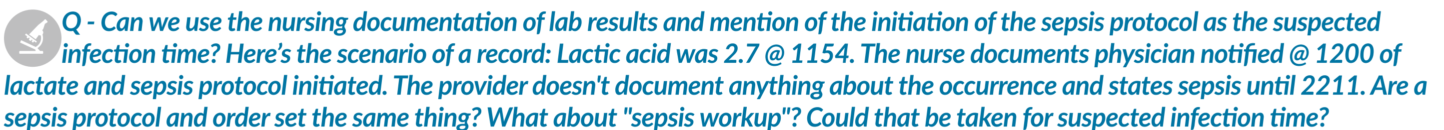
***Q - If there is an "active problem list" embedded within the H&P, can that be used to abstract "severe sepsis" (if there is no historical date associated with it)?***

***A*** - If there is physician documentation of severe sepsis on an active problem list or a problem list then it could be used in abstraction.


***Q - If severe sepsis is determined in urgent care (prior to arrival to ED), do we use the urgent care MD documentation time of severe sepsis presentation, or do we use the ED arrival time? If the ED arrival time is greater than 6 hours from the severe sepsis presentation time, then how do we handle that?***

***A*** - This is another multi-tier answer.

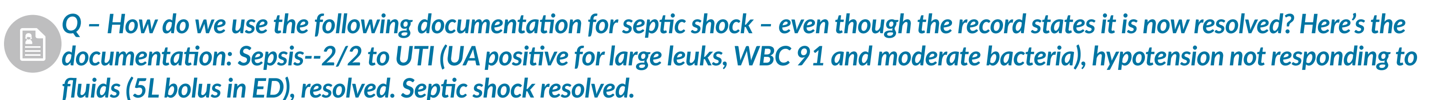
- If severe sepsis is present on arrival to the Emergency Department or severe sepsis is identified in triage (all three clinical criteria must be met or documented during triage), the Severe Sepsis Presentation Time is the time the patient was triaged in the Emergency Department. If more than one triage time is documented (e.g., "Triage started" and "Triage completed") use the later time reflecting triage is completed.
- For patients who arrive to the ED with severe sepsis clinical criteria met or physician/APN/PA documentation of severe sepsis, that bypass triage or a triage time is not documented, use the ED arrival time.
- Therefore, you would use the triage or arrival time for severe sepsis.


***Q - Can we use the nursing documentation of lab results and mention of the initiation of the sepsis protocol as the suspected infection time? Here's the scenario of a record: Lactic acid was 2.7 @ 1154. The nurse documents physician notified @ 1200 of lactate and sepsis protocol initiated. The provider doesn't document anything about the occurrence and states sepsis until 2211. Are a sepsis protocol and order set the same thing? What about "sepsis workup"? Could that be taken for suspected infection time?***

***A*** - Narrative documentation using the term "sepsis" is acceptable since the narrative documentation is not a checklist, alert, or title/heading of an order set. This narrative documentation is outside of the checklist or alert, so it would be acceptable documentation. If there is documentation of "sepsis workup" outside of a checklist or alert, it could be used.
And it's crucial to remember: Documentation of suspected infection, SIRS criteria, and sign of organ dysfunction must be present in the medical record outside of the alert or checklist.

***Q - Should we abstract physician documentation of "shock-suspect septic (distributive)" as septic shock?***

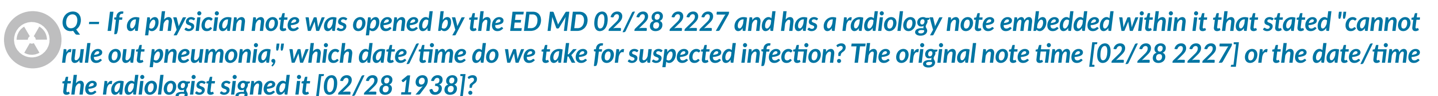
***A -*** This documentation would be sufficient to select "yes" for septic shock.


***Q – How do we use the following documentation for septic shock – even though the record states it is now resolved? Here's the documentation: Sepsis--2/2 to UTI (UA positive for large leuks, WBC 91 and moderate bacteria), hypotension not responding to fluids (5L bolus in ED), resolved. Septic shock resolved.***

***A -*** You would use the documentation to select "no" for septic shock since it says that it is resolved. You can equate this to mean that septic shock is not present.

***Q- If a physician documents, "SIRS due to infectious etiology" would that be acceptable to abstract as possible infection?***

***A -*** Yes, this documentation would suffice suspected infection.


***Q – If a physician note was opened by the ED MD 02/28 2227 and has a radiology note embedded within it that stated "cannot rule out pneumonia," which date/time do we take for suspected infection? The original note time [02/28 2227] or the date/time the radiologist signed it [02/28 1938]?***

***A -*** If there is no specified time associated with the documentation of the suspected infection, you would use the note open time. If the time that the radiologist signed the note is the specified time associated with the suspected infection, you would use this time. If not, you would use the note open time.*

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