Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock: v5.5a Measure FAQs

Questions and Answers

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The following document provides actual questions from audience participants. Webinar attendees submitted the following questions and subject-matter experts provided the responses during the live webinar. The questions and answers have been edited for grammar.

Question 1: **If our target ordered fluid volume (e.g., 4,500 milliliters [mL]) is ran over seven hours, which meets the greater than 125 mL/hour (hr) requirement, how can we assess for *Persistent Hypotension* within the six-hour window to meet the measure if the fluids are still infusing?**

Regardless of when the fluids are completed, you would still assess for *Persistent Hypotension* at that time. If the fluid completion time and *Persistent Hypotension* [were] found to be greater than six hours after *Severe Sepsis Presentation* and you had *Persistent Hypotension*, then you would just select value "2" for septic shock. You would not use the *Persistent Hypotension* found to be greater than six hours after severe sepsis for criteria for septic shock.

Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Broad Spectrum or Other Antibiotic Administration

Question 2: **Slide 14. Would we still answer "No" to giving or administering the antibiotic since the patient did not receive an intravenous (IV) antibiotic?**

For the *Broad Spectrum or Other Antibiotic Administration* data element, an IV or intraosseous (IO) antibiotic is required within 24 hours prior through three hours after the *Severe Sepsis Presentation Time*. If an IV or IO antibiotic was not administered within that time frame, the case would fail the measure prior to reaching the *Broad Spectrum or Other Antibiotic Administration Selection* data element, specifically by selecting value "2" (No) in the *Broad Spectrum or Other Antibiotic Administration* data element.

Question 3: **Slide 15. If the test results for *Clostridium difficile* (C. diff) are never positive, can we select value "1" (Yes), assuming the appropriate C. diff antimicrobials are given?**

To suffice the guidance provided in the *Broad Spectrum or Other Antibiotic Administration Selection* data element, only physician/advanced practice nurse (APN)/physician assistant (PA) documentation identifying the presence of C. diff is required. Positive C. diff test results are not required.

Question 4: **Slide 15. If only oral (PO) Vancomycin is given within the time frame, will the case fail on *Broad Spectrum or Other Antibiotic Administration* because only a PO antibiotic was given?**

Yes. The *Broad Spectrum or Other Antibiotic Administration* data element requires an IV, intramuscular (IM), or IO antibiotic be administered within the 24 hours prior through three hours after the *Severe Sepsis Presentation Time*. If this does not occur, the case would fail the measure prior to reaching the *Broad Spectrum or Other Antibiotic Administration Selection* data element. Because of this data element flow resulting in the case failing, oral Vancomycin with physician/APN/PA documentation identifying the presence of C. diff, would not be considered.

Question 5: **Slide 15. Is Vancomycin now recognized as monotherapy?**

No, slide 15 provides guidance for the *Broad Spectrum or Other Antibiotic Administration Selection* data element in which PO Vancomycin is only acceptable if there is physician/APN/PA documentation identifying the presence of C. diff and oral Vancomycin was administered within three hours after the *Severe Sepsis Presentation Time*.

Question 6: **Slide 15. There is an exemption for patients on IV antibiotics for 24 hours prior to presentation since they are already being treated. Why is the PO Vancomycin for C. diff not treated with the same exemption? For example, patient presented with severe sepsis related to C. diff and has already taken PO Vancomycin for more than 24 hours.**

All severe sepsis patients are required to have an IV antibiotic within 24 hours prior to three hours after the *Severe Sepsis Presentation Time*. The exception for C. diff provided in the *Broad Spectrum or Other Antibiotic Administration Selection* data element only applies to severe sepsis cases where the *Broad Spectrum or Other Antibiotic Administration Time* is within the three hours after the *Severe Sepsis Presentation Time* and the appropriate combination of IV antibiotic(s) are not started within this time frame.

Question 7: **Slide 15. Regarding PO Vancomycin with or without IV Flagyl in suspected C. diff, I understand we can answer "Yes" to the 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*?" However, in the past, if severe sepsis was present, then the patient still required antibiotic(s) from the monotherapy or the combination list. We would then answer "No" to the 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?" Are you saying this is no longer true?**

No, to select value "1" (Yes) for the *Broad Spectrum or Other Antibiotic Administration* data element, an IV or IO antibiotic must be administered within the 24 hours prior to three hours after the *Severe Sepsis Presentation Time*. If the *Broad Spectrum or Other Antibiotic Administration Time* is within three hours after the *Severe Sepsis Presentation Time*, then the *Broad Spectrum or Other Antibiotic Administration Selection* data element must be abstracted. If there is physician/APN/PA documentation identifying the presence of C. diff, then PO Vancomycin would be acceptable.

Question 8: **Slide 15. Does IV Vancomycin meet the criteria for C. diff since the example only includes oral?**

No, per the exception for C. diff provided in the *Broad Spectrum or Other Antibiotic Administration Selection* data element, only PO or rectal Vancomycin is acceptable.

Question 9: **The specifications manual only allows for IV antibiotic administration. How can oral treatment only be acceptable for C. diff infection?**

The *Broad Spectrum or Other Antibiotic Administration* data element requires an IV or IO antibiotic be administered within the 24 hours prior to three hours after the *Severe Sepsis Presentation Time*. If the *Broad Spectrum or Other Antibiotic Administration Time* is within three hours after the *Severe Sepsis Presentation Time*, then the *Broad Spectrum or Other Antibiotic Administration Selection* data element must be abstracted. If there is physician/APN/PA documentation identifying the presence of C. diff, then PO Vancomycin would be acceptable for the *Broad Spectrum or Other Antibiotic Administration Selection* data element.

Question 10: **Would the case fail if only oral Vancomycin or Flagyl are administered since no IV antibiotic was administered and we answered "No" to *Broad Spectrum Antibiotic or Other Antibiotic Administration*? If so, would the**

case not proceed to *Broad Spectrum or Other Antibiotic Selection*?

The *Broad Spectrum or Other Antibiotic Administration* data element requires an IV or IO antibiotic be administered within the 24 hours prior to three hours after the *Severe Sepsis Presentation Time*. If this did not occur value "2" (No) should be selected for the *Broad Spectrum or Other Antibiotic Administration* data element, which will result in the case failing the measure prior to reaching the *Broad Spectrum or Other Antibiotic Administration Selection* data element. Because of this data element flow resulting in the case failing, oral Vancomycin with physician/APN/PA documentation identifying the presence of C. diff would not be considered.

Question 11: **Our providers strongly disagree with the administration of a broad-spectrum IV antibiotic for C. diff, believing this is counter intuitive. Please comment.**

The C. diff exception provided in the *Broad Spectrum or Other Antibiotic Administration Selection* data element most often applies to cases with IV Flagyl and PO Vancomycin administered within the specified time frames. The measure does not require a broad-spectrum IV antibiotic be administered within the 24 hours prior to the *Severe Sepsis Presentation Time*; any IV antibiotic will suffice the *Broad Spectrum or Other Antibiotic Administration* data element.

Question 12: **If an antibiotic was given in a different admission, but within 72 hours, what documentation would be needed from the prior admission? Would we need to scan this documentation from the medication administration record (MAR)?**

If an IV antibiotic was given in the 24 hours prior to *Severe Sepsis Presentation Time* and that same antibiotic was given greater than 24 hours prior to the *Severe Sepsis Presentation Time*, the antibiotic name, route, date and time of administration would be needed. If this information is in the medical record or electronically accessible when abstracting the medical record, it may be used.

Crystalloid Fluid Administration

Question 13: **Slide 19. The guidance states that the volume must be infused. Then, it states that the volume does not need to be infused. This seems contradictory. Does the volume of fluid need to be completely infused?**

Per the guidance, to choose value "1," the target ordered volume must be documented as completely infused. However, complete infusion of the target ordered volume is NOT required within a specified time frame. There must be documentation supporting the fluids were completely infused as evidenced by a start time and rate, duration, or end time. If the target ordered volume is not documented as completely infused, value "2" (No) would be selected.

Question 14: **Slide 19. If the fluids are not completely infused and the abstractor selects value "2," will the case fail based on the *Crystalloid Fluid Administration* data element??**

Yes, if value "2" (No) is selected for *Crystalloid Fluid Administration*, the case will fail the measure.

Question 15: **Slide 19. If the patient weighs 75 kilograms (kg) and the physician orders "Lactated Rings (LR) two liters IV bolus now," was the target fluid volume infused?**

No, this documentation alone would not suffice to consider the target ordered volume completely infused. While this physician fluid order is complete, documentation of an infusion start time and rate, duration, or end time is needed.

Question 16: **Slide 20. If the volume isn't required to be infused within a specified time frame, how do we assess for *Persistent Hypotension* in the hour following fluid resuscitation and a vasopressor within the six-hour time frame? We thought we had to infuse fluids within five hours and monitor the blood pressure for one hour, so the vasopressor can be started within the six-hour time frame. Please explain why this is not the case.**

While complete infusion of the target ordered volume is not required within a specified time frame, there must be documentation supporting the target ordered volume was completely infused. To support complete infusion there must be a start time and rate, duration, or end time documented. If there is not documentation supporting the target ordered volume was completely infused, value "2" (No) should be selected for *Crystalloid Fluid Administration* and the case will fail the measure.

Persistent Hypotension is assessed in the hour following the completion of the target ordered volume, regardless of when the target ordered volume is completely infused. Currently, if *Persistent Hypotension* was found greater than six hours after septic shock and vasopressors were not started within six hours of septic shock, the case would fail *Vasopressor Administration* based on the specified time frame for *Vasopressor Administration*.

Question 17: **Slide 20. Can you clarify the statement regarding the completion of the crystalloid fluids? It seems it is required to determine *Septic Shock Present* which mentions "...conclusion of the target ordered volume..." For the calculation of completion of crystalloid fluids in *Septic Shock Present,* do all 30 ml/kg crystalloid fluids need to be completed or is volume within 10 percent allowable?**

Slide 20 states, "The target ordered volume is not required to be completed within a specified time frame." This statement must be taken within the context of the information in slide 19 because both statements are from the second bullet point in the abstraction guidance for the *Crystalloid Fluid Administration* data element. To clarify, the full target ordered volume must be completely infused. The full target ordered volume does not, however, need to be completely infused within a specific time frame.

Question 18: **Slide 22. Do we calculate the end time of the acceptable 1890 mL or do we use the end time for the full 2000 mL when looking for *Persistent Hypotension* in the hour following fluid administration?**

The completion time of the ordered volume (2000 mL) would be calculated since the ordered volume of crystalloid fluids is within 10 percent of the 30 mL/kg volume based on the patient's weight.

Question 19: **Slide 22. Please clarify how slide 22 is not contradictory to slide 23.**

Both slide 22 and 23 indicate the volume of fluid that should be administered is the target ordered volume. Each slide however, describes a different approach to the amount of the target ordered volume.

Slide 22 is providing guidance regarding how to determine the target ordered volume when it is less than 30 mL/kg but within 10 percent of 30 mL/kg. The target ordered volume must be 30 mL/kg or a volume within 10 percent

of 30 mL/kg.

In the question on slide 23, the target ordered volume is based upon 30 mL/kg and therefore determined by the patient's weight of 52 kg and the ordered volume of 30 mL/kg. Therefore, the target ordered volume for the example on slide 23 would be 1560 mL based on the ordered volume of 30 mL/kg.

Question 20: **Slide 22. If you started normal saline (NS) at 126 mL/hr within the three-hour time frame for a total of 30 mL/kg, would this meet the criteria?**

If there was a single order for a volume of 30 mL/kg to infuse at 126 mL/hr that was started within three hours after *Initial Hypotension* or *Septic Shock Present*, this infusion would be acceptable.

Question 21: **Slide 22. When the volume is within 10 percent, could you clarify what amount we use to calculate the end of the target volume? Is it the exact 10 percent?**

The volume of crystalloid fluids ordered would be used. Per the example scenario on slide 22, 2000 mL of crystalloid fluids are ordered and 2000 mL is within 10 percent of the 30 mL/kg volume based on the patient's weight of 70 kg. Therefore, 2000 mL would be the target ordered volume and the completion time of 2000 mL would be determined.

Question 22: **Slide 23. Is this only if the order is placed as a single 30 mL/kg fluid order?**

If the volume ordered is 30 mL/kg or more, the target ordered volume of crystalloid fluids would be 30 mL/kg based on the patient's weight.

Question 23: **Slide 23. Wouldn't the 1404 mL be within 10 percent because 1560 minus 10 percent is 1404? Why was the 10 percent rule not applicable in this scenario?**

The "10 percent rule" applies to the volume of crystalloid fluids ordered. The volume ordered can be within 10 percent of 30 mL/kg. If the ordered volume of crystalloid fluids is equivalent to 30 mL/kg or more, the 30 mL/kg volume is used for the target ordered volume.

The question on slide 23 refers specifically to the fluid volume that must be infused, to which the 10 percent rule does not apply. The full amount ordered must be infused.

Question 24: **If an order identifies the appropriate volume and type of fluid, but does not identify the rate, does the emergency department (ED) physician documentation stating "IV fluid bolus" suffice for crystalloid fluid administration?**

No, if the type of fluid, volume of fluid, rate, or infusion duration is missing in the order, do not use the order toward the target ordered volume.

Question 25: **Is the fluid used to dilute medications one of the acceptable fluids, such as normal saline (NS), to include for the total volume of crystalloid fluids?**

Yes, only crystalloid solutions or balanced crystalloid solutions would be used toward the target ordered volume.

Question 26: **For crystalloid infusion administration, can we use the Intake and Output (I&O) documentation, showing when the volume was documented, as input for the end or completion time? If the ED physician ordered "NS 30 mL/kg IV Bolus" and the patient was transferred to the intensive care unit (ICU) prior to the end of the bolus, can we use the I&O sheet from ICU with the NS hourly intake to meet the bolus?**

If the infusion end/completed time is in the I&O documentation, this would be acceptable. However, if only the hourly intake is documented without an infusion end/completed time, this would not suffice for documentation of the fluid bolus end/completed time.

Question 27: **If the target ordered volume was completely infused in nine hours from "Time Zero," will that still pass the measure?**

As long as the target ordered volume was ordered and started within the specified time frame and there is a rate, duration, or end time, the infusion would be acceptable.

Question 28: **If there are two separate orders for 1000 liters (L), is the last order used as the "start time"?**

If there are multiple fluid orders used for the target ordered volume, the start time of the infusion that completed the target ordered volume would be abstracted for the *Crystalloid Fluid Administration Date* and *Time*. Therefore, if the second 1000 mL infusion in your example completed the target ordered volume, the start time of the second infusion would be abstracted.

Question 29: **If the patient is being transferred to a higher level of care would the case fail the measure since the target ordered volume would not be completed prior to transfer?**

If a patient's discharge time is within six hours after the *Severe Sepsis Presentation Time*, the case would be excluded at the Sepsis Discharge Timing calculation in the algorithm. If the patient was discharged or transferred to another facility more than six hours after the *Severe Sepsis Presentation Time*, all required elements of the measure would need to be completed for the case to pass the measure.

Question 30: **The *Crystalloid Fluid Administration* data element is still confusing. To make it easier, can you advise if the infusion must be complete within the three-hour time frame?**

Per the guidance, to choose value "1," the target ordered volume must be documented as completely infused. However, the target ordered volume is NOT required to be completely infused within the specified time frame. Therefore, the fluids must be documented as completely infused as evidenced by documentation of a start time and rate, duration, or end time, but the fluids are not required to be completely infused within a specified time frame.

Question 31: **Is it acceptable if the fluid is not ordered all at once but is patched together with antibiotics and emergency medical service (EMS) fluids?**

Yes, it is acceptable to meet the target ordered volume via multiple fluid orders and multiple infusions.

Question 32: **If the fluid boluses are ordered separately, why do all three need to be started within the first three hours? Isn't the intention to have the fluid resuscitation complete in the six-hour window? Why are we penalizing hospitals for doing the right thing?**

Acceptable crystalloid fluids are fluids ordered within the six hours prior through three hours after a triggering event (i.e., *Initial Hypotension* or *Septic Shock Present*). The measure does not include a specified time frame in which the target ordered volume of crystalloid fluids must be completed.

Question 33: **What is the minimum dose of fluids to count?**

The minimum volume of crystalloid fluids is dependent upon each patient's weight. The measure does not include a universal minimum fluid volume. The acceptable total volume of crystalloid fluids ordered must be 30 mL/kg or within 10 percent less than 30 mL/kg.

Question 34: **Since the update, I am asked to complete the crystalloid fluid question even when the patient has a lactate less than 4.0, does not have *Initial Hypotension*, and there is no documentation of septic shock. Are these patients required by the measure to receive 30 mL/kg?**

Per the updated algorithm for manual v5.5a, if value "2" (No) is selected for *Initial Hypotension* and *Septic Shock Present*, the case would not reach the *Crystalloid Fluid Administration* data element. If your tool continues to require the abstraction of the *Crystalloid Fluid Administration* data element after value "2" (No) is selected for *Initial Hypotension* and *Septic Shock Present*, your vendor will need to address the concern.

Question 35: **Why are we not able to use IV fluids that are ordered at a rate of less than or equal to 125 mL/hr but, within that order, the rate is increased to greater than 125 mL/hr?**

Crystalloid fluids ordered at 125 mL/hr or less are considered maintenance fluids rather than fluids administered for resuscitation. If a crystalloid infusion rate is increased during an infusion, fluids administered at 126 mL/hr or greater would be acceptable.

Question 36: **The Notes for Abstraction for the *Crystalloid Fluid Administration Time* data element state, "If multiple orders are written that total the target volume, use the start time of the crystalloid fluid infusion that completes the target ordered volume." If following the guidance, is the earliest time NOT the time abstracted and, with no required completion time frame, is the order completing the target volume initiated outside the three-hour time frame following presentation?**

If the target ordered volume is administered via multiple fluid orders, the start time of the infusion completing the target ordered volume may occur greater than three hours after *Initial Hypotension* or *Septic Shock Present*. In this scenario, value "2" (No) would most likely be abstracted for *Crystalloid Fluid Administration*.

Question 37: **Will the case fail the measure if there is no end time documented?**

If an end time is not present, a rate or infusion duration is acceptable to use in place of an end time. The rate, duration, or end time is used to confirm the crystalloid fluids were completely infused. If none of these are documented for an infusion, that infusion would not be used toward the target ordered volume of crystalloid fluids.

Question 38: **If a physician documents 30 ml/kg NS using ideal body weight due to obesity (body mass index [BMI] greater than 30), but the patient's actual BMI is 26, do you use the lesser amount of fluids or the actual weight for the 30 ml/kg?**

No, with the required physician/APN/PA documentation present in the medical record, the documented ideal body weight (IBW) would be used to determine the target ordered volume of crystalloid fluids.

Initial Hypotension

Question 39: **Slide 25. Does the mean arterial pressure (MAP) need to be documented to use the MAP or should we use a formula during abstraction to determine what the MAP would be?**

Only use MAP readings that are documented within the medical record. The abstractor would not calculate the MAP during chart abstraction.

Question 40: **Slide 25. Does the decrease in systolic blood pressure (BP) of greater than 40 millimeters of mercury (mm/hg) require physician documentation for it to be included as *Initial Hypotension*?**

Yes, to use a decrease in systolic BP by greater than 40 mm/hg, there must be physician/APN/PA documentation present in the medical record indicating a greater than 40 mm/Hg decrease in systolic BP has occurred and is related to infection or severe sepsis and not other causes.

Question 41: **Slide 25. If criteria for *Initial Hypotension* is within six hours prior to or three hours after, then why would the BP after presentation time be considered? This is confusing.**

The time frame for *Initial Hypotension* is six hours prior to through six hours after severe sepsis presentation. Additionally, the two hypotensive readings must be within three hours of each other to select value "1" (Yes) for *Initial Hypotension*.

Question 42: **Slide 25. In previous questions and answers, BP drops of 40 or more required documentation that the drop was due to infection. Is this still applicable?**

Yes, to use a decrease in systolic BP by greater than 40 mm/Hg, there must be physician/APN/PA documentation present in the medical record indicating a greater than 40 mm/Hg decrease in systolic BP has occurred and is related to infection or severe sepsis and not other causes.

Question 43: **Slide 26. The guidance on slide 25 states the time frame is six hours prior or within six hours following *Severe Sepsis Presentation Date* and *Time*. This implies these two time periods are exclusive of each other and the answer would be "D" (82/51 at 18). Why would the answer be 88/57 at 1720?**

The time frame for *Initial Hypotension* is six hours prior through six hours after *Severe Sepsis Presentation*. Additionally, the two hypotensive readings must be within three hours of each other to select value "1" (Yes) for *Initial Hypotension*.

The hypotensive reading at 1230 is within the specified time frame for *Initial*

Hypotension. However, this hypotensive reading is not within three hours of another hypotensive blood pressure reading.

Hypotensive readings at 1555, 1720, and 1800 are within the specified time frame for *Initial Hypotension* and within three hours of each other. The guidance states: "For patients with more than two hypotensive blood pressures in the time period of six hours prior to or within six hours following *Severe Sepsis Presentation Date* and *Time*, use the time of the second hypotensive BP documented within the time period." Thus, the second reading at 1720 would be used.

Question 44: **Is it still true that if 30 cc/kg fluid is completed prior to *Initial Hypotension*, then the patient does not have *Initial Hypotension*?**

Yes, *Initial Hypotension* is hypotension that is present prior to the target ordered volume of crystalloid fluids being completely infused. Therefore, if the target ordered volume of crystalloid fluids is completed prior to the second hypotensive reading reflecting *Initial Hypotension*, value "2" (No) would be selected for *Initial Hypotension*.

Question 45: **In terms of *Initial Hypotension*, if the patient has two low BPs prior to *Severe Sepsis Presentation*, how can we be held accountable to the 30 ml/kg IV fluid requirement? At the time of *Initial Hypotension*, it may not be known that infection is the cause or the patient may not have met the two systemic inflammatory response syndrome (SIRS) criteria.**

Crystalloid Fluid Administration is based on resuscitation following a triggering event. The triggering events per the *Crystalloid Fluid Administration* data element are *Initial Hypotension* and *Septic Shock Present*. Therefore, *Crystalloid Fluid Administration* is not based on the *Severe Sepsis Presentation Time*, it is based on the event that would trigger the need for fluid resuscitation.

Question 46: **The patient has a BP of 88/56 at 1400; then, at 1500, the patient has a MAP of 60 and BP of 92/58. Is *Initial Hypotension* at 1500 due to a MAP less than 65 and a systolic BP less than 90 at 1400?**

Correct. The *Initial Hypotension Time* would be 1500 in this scenario based on the hypotensive systolic reading of less than 90 mm/Hg (88 mm/Hg) at 1400 and a MAP less than 65 (60) at 1500.

Question 47: **Are IV fluids based on septic shock or *Initial Hypotension*? What do you mean by septic shock?**

Crystalloid fluids are required when value "1" (Yes) is selected for *Initial Hypotension* or for *Septic Shock Present*.

The *Septic Shock Present* data element provides guidance for determining if septic shock is present, which may be based on physician/APN/PA documentation of septic shock or meeting the septic shock clinical criteria.

Question 48: **How do you answer the *Initial Hypotension* question when the target fluids are never fully infused?**

If two hypotensive readings are documented within the specified time frame before the target crystalloid fluids were documented as completely infused, value "1" (Yes) would be selected for the *Initial Hypotension* data element. If the target ordered volume of crystalloid fluids was documented as completely infused prior to the second hypotensive reading that reflected *Initial Hypotension*, then value "2" (No) would be selected for *Initial Hypotension*.

Question 49: **Why are we treating *Initial Hypotension* if it is present six hours prior to *Severe Sepsis Presentation*? Example: Severe sepsis is noted by the ED physician at 1730. EMS determines *Initial Hypotension* by the first reading of 85/46 at 1145 and the MAP second reading of 64 on arrival at 1210:**

1) If the EMS record is not readily available and scanned in later, the ED physician is not even aware of *Initial Hypotension* presence.

2) The need to start the target volume of 30 cc/kg is due by 1510, which is greater than two hours before *Severe Sepsis Presentation* or recognition.

3) By the algorithm, if less than 30 cc/kg is ordered, it fails the measure due to not enough fluids. If 30 cc/kg is ordered, initiated, and completely infused with the target bag hung at 1820, it also fails the measure due to fluids not timely (greater than 180 minutes from *Initial Hypotension*).

Are the fluids given primarily for the hypotension being present or is there still a need to establish the septic shock? Please provide rationale

so this could be used for the physician's education.

Crystalloid Fluid Administration is based on fluid resuscitation following a triggering event. The triggering events per the *Crystalloid Fluid Administration* data element are *Initial Hypotension* and/or *Septic Shock Present*. Therefore, *Crystalloid Fluid Administration* is not based on the *Severe Sepsis Presentation Time*, it is based on the event that would trigger the need for fluid resuscitation.

This is supported by the *Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016*, which note that effective fluid resuscitation is crucial for stabilization of sepsis-induced tissue hypo-perfusion or septic shock. The guidelines recommend at least 30 mL/kg of IV crystalloid fluid if either is present. Hypotension in a patient with severe sepsis is considered sepsis-induced hypo-perfusion and septic shock can manifest as severe sepsis with a lactate level greater than 4 mmol/L. If the patient remains hypotensive after the fluids are completely infused, they are considered to have septic shock. In this case, the fluids would have been infused prior to the presence of septic shock.

Initial and Persistent Hypotension

Question 50: **Slide 27. Do we only look at the systolic BP? In the example, the diastolic BP is lower, but you only referred to the systolic. Additionally, how does a low MAP fit into this if a baseline MAP is not documented?**

In the example on slide 27, an APN documented the patient's baseline BP as 82/58. Therefore, systolic BPs less than 82 would be considered hypotension for this patient and systolic BPs 82 or greater would be considered normal. The diastolic readings are not used to meet the measure criteria. In cases such as the example on slide 27, if the physician/APN/PA documents the blood pressure of 82/56 as normal for the patient but does not include any reference to a baseline MAP, then a MAP less than 65 would be used as hypotension.

Question 51: **Slide 28. The example indicates that the low BP is secondary to Lasix. What if the patient is no longer on Lasix, would we still not use a BP greater or equal to 80?**

Correct, the hypotensive reading(s) would not be used as they are documented as due to the medication. This continues to apply even after the

medication has been discontinued.

Question 52: **Slides 29 and 30. If the physician notes "hypotension, related to dehydration, not sepsis," would the hypotensive value still be used?**

Slides 29 and 30 only refer to documentation where the hypotensive readings are due to an acute condition and, in those cases, the hypotensive readings would be used. The question includes the caveat that the hypotension is also not related to sepsis. The hypotensive readings documented as due to an acute condition such as dehydration would not be used in this case because the physician/APN/PA also documents that the hypotension is not due to sepsis.

Question 53: **Slide 30. Why would you use the low BP when the physician notes "hypotension due to acute exacerbation of CHF"? Congestive heart failure (CHF) is not an infectious process.**

Hypotensive readings or hypotension documented as due to an acute on chronic condition are used because severe sepsis often exacerbates an acute on chronic condition. Since the hypotensive readings may be due to an acute on chronic condition that is actually caused by the infection or severe sepsis, the hypotensive readings would still be used.

Question 54: **Slide 31. For the *Initial Hypotension* example, how is it determined that dehydration is infectious but a gastrointestinal (GI) bleed is not? Either could be caused by something else and neither is infectious on its own.**

Slide 31 relates to hypotension due to blood loss from a GI bleed. To determine if the GI bleed is a non-infectious source of the blood loss (which is resulting in hypotension), the guidance states to refer to *Severe Sepsis Present* criteria "a" to determine if the source of the acute condition is an infection. Criteria "a" within the *Severe Sepsis Present* data element indicates, if other medical resources (such as a medical dictionary) identify a GI bleed could be caused by an infection or non-infection, there must be additional documentation in the medical record that supports an infection is causing the GI bleed.

Question 55: **Regarding "hypotension present" after fluid administration, if only one BP below 90 is documented in the hour following and the next BP is**

documented one hour and five minutes following and is below 90, do we document no hypotension since only one BP was below 90 in the one hour following completion of the infusion?

For determining *Persistent Hypotension*, if only one reading is documented in the hour to assess for *Persistent Hypotension* and that reading is hypotensive, value "3" (No or UTD) would be selected for *Persistent Hypotension*. If only one reading was documented and that reading was normal, value "2" (No) would be selected. Blood pressure readings documented outside of the one hour to assess for *Persistent Hypotension* would not be used.

Question 56: **If it is documented that hypotension is normal for the patient, but no values are documented, should the low BPs be used?**

To meet the criteria, hypotensive readings (systolic BP less than 90 or MAP less than 65) must be documented.

Question 57: **After completion of the 30 mL/kg fluids, if there are two systolic BPs above 90 documented in the chart by the nurse, do still we need a re-assessment?**

If value "2" (No) is selected for *Persistent Hypotension* based on the two normal BP readings in the hour to assess for *Persistent Hypotension*, the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element would only be reached if the *Initial Lactate Level Result* was greater than or equal to 4. If value "2" (No) was selected for *Persistent Hypotension* and values "1" or "2" were selected for the *Initial Lactate Level Result*, the case would proceed to the numerator population and not continue to the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element.

Question 58: **Patients often become hypotensive during hemodialysis due to fluid shifts. Can this low BP be excluded?**

The measure does not provide guidance to exclude hypotensive readings documented during dialysis. If, however, the provider documented that hypotension during dialysis was due to being on dialysis, then they have attributed the hypotension to the dialysis treatment and the low BP during dialysis could be excluded.

Initial Lactate Level Collection

Question 59: **Slide 32. Do the multiple lactate levels need to be documented in the same note?**

No, the lactate levels would not need to be within the same note. The guidance related to the abstraction of the *Initial Lactate Level Collection* when multiple lactates were collected refers to multiple lactate collections within the specified time period. Therefore, the highest lactate level result which was collected within the specified time period would be used for the *Initial Lactate Level Collection*.

Question 60: **Slide 32. A lactic acid test was done by respiratory therapy and the same results were later reported out by the lab. It looks like four tests were done, but only two had different reported out and collected times. Should we treat it as four results or as two results reported by different departments?**

To accurately respond to your questions, further details will be required. Please submit this question via the online Questions & Answers (Q&A) tool found on *QualityNet.org*, and we would be happy to review this scenario further.

Question 61: **Slide 33. Is a lactate drawn exactly at *Severe Sepsis Presentation Time* considered prior to or following presentation?**

If a lactate is collected exactly at the *Severe Sepsis Presentation Time*, this lactate collection is considered at the time of or after the *Severe Sepsis Presentation Time*, and would be in the specified time frame.

Question 62: **Slide 33. If there are two lactates within the specified time period and the second is higher, does the second value become the initial lactate and do we repeat it?**

If there are multiple lactates collected within the specified time period, the lactate collection with the highest result would be used for the *Initial Lactate Level Collection*. Therefore, if the second lactate level collected within the specified time period has the highest result, this would be used for the *Initial Lactate Level Collection*. Whether a *Repeat Lactate Level Collection* is required will depend on the *Initial Lactate Level Result*. If the *Initial Lactate Level Result* is greater than 2.0, a *Repeat Lactate Level Collection* must be

performed within the specified time period.

Question 63: **Slide 34. The presenter stated that the repeat lactate level is the second one that is collected. Is that true if the second level is not after *Severe Sepsis Present*?**

In reference to slide 34, it was stated that the *Repeat Lactate Level Collection* is the second of two possible lactate level collections required for the measure. Therefore, the name is "*Repeat Lactate Level Collection*" since this is the second of two possible collections.

The second lactate level would be used for the *Repeat Lactate Level Collection* only if it is collected within six hours after the *Severe Sepsis Presentation Time*.

Question 64: **Slide 34. Do you use the lactic acid resulted time or drawn time for the *Initial Lactic Level Collection*?**

For the *Initial Lactate Level Collection* data elements, the collection time of the lactate is used.

Question 65: **Slide 35. What if an earlier elevated lactate is used by the provider to diagnose severe sepsis? For example, the lactic result at 1545 is the organ dysfunction and the source of infection is documented at 1640. Would the lactate at 1545 be considered the initial lactate?**

No, the lactate result used for evidence of organ dysfunction to establish *Severe Sepsis Present* will not necessarily be the same lactate that meets criteria for the *Initial Lactate Level Result*. According to the *Initial Lactate Level Collection* data element, if there are multiple lactate levels drawn within the specified time frame, the lactate drawn PRIOR to the *Severe Sepsis Presentation Time* with the HIGHEST level would be the *Initial Lactate Level*. Since the highest lactate level on slide 35 is the one at 1415 and it is within six hours prior to presentation, it would be used as the *Initial Lactate Level Result*.

Question 66: **If the lab titled "repeat lactate four hours after initial lactate" and this is the lactate with highest level drawn prior to the *Severe Sepsis Present,***

does it become the initial lactate even if it says "repeat" in the title?

The *Initial Lactate Level Collection* and *Repeat Lactate Level Collection* data elements determine which value is considered the initial and repeat lactates for purposes of the measure. If there are multiple lactates collected within the specified time period, the lactate collection with the highest result would be used for the *Initial Lactate Level Collection*. The lab title "repeat lactate four hours after initial lactate" does not meet the criteria established in the data elements to consider this lactate as the repeat lactate.

Question 67: **Please discuss how the recent changes to the lactate level abstraction (i.e., the highest within the time frame) have affected the *Repeat Lactate Level Collection*? Guidelines state the repeat lactate must be the next lactate after the initial and it must be after *Severe Sepsis Present*. This is causing some fall-outs for repeat lactate levels drawn after the initial level but before *Severe Sepsis Present*. Will this be changed soon?**

The updates to the *Initial Lactate Level Collection* data element, regarding the abstraction of the highest lactate value within the time frame, were based on provider feedback regarding the lactate typically used to establish septic shock.

The *Repeat Lactate Level Collection* is the next lactate level collection after the *Initial Lactate Level Collection*, but the *Repeat Lactate Level Collection* must still occur within the six hours following *Severe Sepsis Presentation Time*. Therefore, if there are multiple lactate level collections within the six hours prior to the *Severe Sepsis Presentation Time* and no lactate collections after the *Severe Sepsis Presentation Time*, value "2" (No) would be selected for the *Repeat Lactate Level Collection* because a lactate collection was not performed within the specified time period for the *Repeat Lactate Level Collection*. We are reviewing the concern mentioned regarding the *Repeat Lactate Level Collection* time frame with the measure stewards.

Question 68: **If two lactate levels are collected after severe sepsis and the second is the highest, which is the initial lactate? Would the case then fail because a repeat level was not done after the highest result was completed?**

If multiple lactate levels are drawn only in the three hours after the *Severe Sepsis Presentation Time*, use the lactate with the HIGHEST level drawn within this time frame. In this scenario, if the second lactate collected within the three hours after the *Severe Sepsis Presentation Time* is the highest result

and greater than 2.0, a *Repeat Lactate Level Collection* would be required. If a *Repeat Lactate Level Collection* is not performed, value "2" (No) would be selected.

Question 69: **In our facility, we stop collecting lactates if the lactate drawn prior to severe sepsis is down trending. This causes failures because no repeat lactate levels were drawn from severe sepsis up to six hours later. Can you please provide rationale for the revision in the guidelines?**

Initial Lactate Level Collection data element updates, regarding the abstraction of the highest lactate value within the time frame, were based on provider feedback regarding the lactate typically used to establish septic shock.

Question 70: **If a point-of-care testing (POCT) lactate was drawn and resulted in a sign of organ dysfunction at the time of severe sepsis presentation, do we consider that value before or after severe sepsis start time?**

If a lactate is collected exactly at the *Severe Sepsis Presentation Time*, this lactate collection is considered at the time of or after the *Severe Sepsis Presentation Time* and would be in the specified time frame.

Question 71: **If the lactate is the sign of organ dysfunction and is at the time of *Severe Sepsis Present,* should I abstract this as the initial lactate? Would we still need to look for a higher time in the next three hours?**

The lactate collection at the time of the *Severe Sepsis Presentation Time* may be used for the *Initial Lactate Level Collection*. However, further lactate level results within the three hours after the *Severe Sepsis Presentation Time* would also be reviewed to ensure the highest lactate level result within the time period is abstracted for the *Initial Lactate Level Collection*.

Question 72: **If the initial lactate acid result makes the patient meet severe sepsis criteria would you use that result as your *Initial Lactate Level Result* and not use any other result in the specified time frame?**

No, the lactate result used for evidence of organ dysfunction to establish *Severe Sepsis Present* may or may not be the *Initial Lactate Level Result*. Regardless of the lactate result used for evidence of organ dysfunction, the guidance within the *Initial Lactate Level Collection* data element would be followed to determine the *Initial Lactate Level Collection*.

Question 73: **If the physician documents that the elevated lactic acidosis is related to liver disease, does this exclude the use of all lactic acid results for determining organ dysfunction?**

If physician/APN/PA documentation attributes the elevated lactate levels to a chronic condition, and this documentation is within the specified time period, the elevated lactate level(s) would not be used.

Question 74: **The initial lactic acid is the highest and is the first the physician treats with fluids. A second lactic acid is less than two and is prior to severe sepsis time. Since the patient has responded, we stop collecting lactic acids. Why is repeat lactic acid after severe sepsis time and not after treatment?**

The updates to the *Initial Lactate Level Collection* data element, regarding the abstraction of the highest lactate value within the time frame, were based on provider feedback regarding the lactate typically used to establish septic shock.

The *Repeat Lactate Level Collection* is the next lactate level collection after the *Initial Lactate Level Collection*, but the *Repeat Lactate Level Collection* must still occur within the specified time period. Therefore, if there are multiple lactate level collections within the six hours prior to the *Severe Sepsis Presentation Time* and no lactate collections after the *Severe Sepsis Presentation Time*, value "2" (No) would be selected for the *Repeat Lactate Level Collection* because a lactate collection was not performed within the specified time period for the *Repeat Lactate Level Collection*. We are reviewing the concern mentioned regarding the *Repeat Lactate Level Collection* time frame with the measure stewards.

Question 75: **The patient had a lactate of 2.1 at 1600, which served as end organ dysfunction and the third element needed for *Severe Sepsis Present*. At 1645, the lactate results were 3.5. Which would be the initial lactate?**

In this scenario, both lactate level collections occur within the three hours after the *Severe Sepsis Presentation Time* of 1600. The *Initial lactate Level Collection Time* would be 1645 because the higher result of 3.5 occurred at this time.

Question 76: **Since there hasn't been a concrete link between sepsis and lactic acidosis will CMS ever get away from requiring lactic acids to be completed?**

Thank you for the question. The Surviving Sepsis Campaign recommends lactate collection to inform diagnosis and treatment for severe sepsis and septic shock cases. At this time, CMS plans to retain lactate level collection and results as part of the measure specifications.

Persistent Hypotension

Question 77: **Slide 38 through 40. What about the minimum target volume of 10 percent? When can you calculate that out?**

The measure does not provide a "minimum" volume of fluids that must be administered. A volume within 10 percent of the 30 mL/kg volume is acceptable only when a volume within 10 percent of 30 mL/kg is ordered. When a volume within 10 percent of 30 mL/kg is ordered, the volume of fluids ordered becomes the "target ordered volume." For example, if the patient required 2100 mL based on a weight of 70 kg and the physician ordered 2000 mL, administering the complete target ordered volume of 2000 mL is acceptable because this volume was ordered and within 10 percent of 30 mL/kg. The calculation to determine the completion time of the target ordered volume remains the same. In this example, abstractors should calculate the completion time for the 2000 mL target ordered volume.

Question 78: **Slides 38 through 40. The examples in these slides are very different from the ones provided in the specifications manual. With charts being validated, I am worried I have miscalculated the *Persistent Hypotension* time. How can I rectify this for validation?**

The examples in the *Persistent Hypotension* data element provide guidance for determining the completion time when a single order for the target ordered volume is used. Slides 38–40 provide an example for determining the completion time when the target ordered volume is met using multiple, overlapping fluid orders.

You cannot make changes to your abstraction after a case is submitted. If a case is selected for validation and a mismatch is identified, you may request an educational review of the mismatch.

Question 79: **Slide 38. In the example, the Vancomycin does not indicate the type of fluid it is mixed in; it could be five percent dextrose (D5W), lactated ringers (LR), or NS. Most IV antibiotics are mixed in D5W. Can we assume that this is a crystalloid fluid or must we show proof on the medication order or MAR of the fluid used? If not, why did you include this in the volume infused?**

Fluid orders are required to include the type of fluid, which must be a crystalloid solution or balanced crystalloid solution. Fluids that are not a crystalloid solution or balanced crystalloid solution would not be used toward the target ordered volume. Therefore, the fluids mixed with IV Vancomycin on slide 38 must be a crystalloid solution or balanced crystalloid solution to count toward the target ordered volume. If the IV Vancomycin in this example was administered with D5W, for example, the dilution fluids would not be used as this is not a balanced crystalloid solution.

Question 80: **Slide 38. Are we required to include all of the antibiotic fluid amounts in the IV fluid bolus or can we just abstract the true IV fluid bolus amounts?**

If the fluids used to dilute a medication are ordered and started within the specified time frame and started prior to the completion of the target ordered volume, the fluids used to dilute the medication would be used.

Question 81: **Slide 38. If the physician orders fluids at 30 mL/kg, I use that order as the start and end time. Should I also consider other medications given at the same time, like antibiotics, with this type of order?**

Yes, all crystalloid fluids ordered and started within the specified time frame and started prior to the completion of the target ordered volume would be used. This includes fluids used to dilute the medication.

Question 82: **Slide 38. If you are running two infusions at the same time, with each infusion running at 100 mL/hr, for a total of 200 mL/hr, why can we not count both towards the total volume needed? I know the single rate of each is less than the rate needed, but the combined rate is above the rate needed.**

Fluids infusing at 125 mL/hr or less are considered maintenance fluids rather than fluids used in resuscitation. Therefore, only fluids infused at a rate greater than 125 mL/hr would be used toward the target ordered volume. The *Crystalloid Fluid Administration* data element does not make an allowance for combining infusion rates.

Question 83: **Slide 38. Why can't we clear our pump volumes at the end of the four infusions?**

The measure does not provide guidance regarding the devices used for infusion of the IV fluids. The intent of this question is unclear. To ensure we provide the most accurate response, please submit your question and additional information regarding clearing the pump volumes via the online Q&A tool found on *QualityNet.org*,

Question 84: **Slide 38. For calculating the time for *Persistent Hypotension* assessment post fluids, if we are allowed to use fluids prior to *Severe Sepsis Presentation Time* or *Septic Shock Presentation Time*, do we only calculate the remaining fluids or do we go back and calculate from the first fluids given?**

Determining the target ordered volume completion time is based on all crystalloid fluids ordered and started within the six hours prior to three hours after *Initial Hypotension* or the *Septic Shock Presentation Time*. Therefore, all fluids ordered and started within this time frame are used, not simply the remaining fluids after a presentation time.

Question 85: **Slide 38. In the example, why must the crystalloid fluid be the target ordered volume?**

The target ordered volume is the acceptable fluid volume that is required when *Initial Hypotension* or septic shock is present. Crystalloid fluid volumes ordered that are equivalent to 30 mL/kg or within 10 percent less than 30 mL/kg are considered the target ordered volume.

Question 86: **Slide 38 and 39. Do you expect an ICU nurse or any other nurse to calculate the target ordered volume while taking care of patients? As an abstractor, retrospective abstractions would be feasible, but this seems unrealistic while trying to care for patients.**

The measure specifications provide guidance for abstractors to retrospectively determine the completion time of the target ordered volume that was infused. This is done during abstraction of the medical record and after care has already been provided. There is no expectation for bedside nurses to follow the measure specification guidance for providing bedside care. The target volume is what the provider determines and orders based on the patient weight. To meet the intent of the measure, the provider should order 30 mL/kg of crystalloid fluids.

Question 87: **Slide 39. Do you comprehend the burden you are putting on an abstractor? It would take hours to abstract a chart and do this kind of math for one chart. This is just ridiculous.**

Thank you for the comments. The measure stewards, measure writers, and CMS recognize the burden of abstraction for SEP-1 and continually focus on reducing abstraction burden with each revision of the manual.

Question 88: **Slide 39. If 30 mL/kg of IV fluid is ordered and there is a 500 mL infusion of Vancomycin running during this infusion time, would we use only the 30 mL/kg order to determine when to assess for *Persistent Hypotension* or use both infusions to determine this?**

If the fluids used to dilute a medication are ordered and started within the specified time frame and started prior to the completion of the target ordered volume, the fluids used to dilute the medication would be used.

Question 89: **Slides 40. Would this calculation still need to be need done if there are documented end times for each of these fluids?**

Yes, the calculation to determine the completion time of the target ordered volume would still be needed, unless there was a documented end/stop/completion time for the exact target ordered volume.

Question 90: **Slide 40. Why is 1000 not acceptable?**

The completion time of only the target ordered volume should be calculated. In the example on slides 38–40, the target ordered volume is 30 mL/kg or 2000 mL. Because of the multiple infusions running at the same time, 2000 mL is completely infused by 0918. By 1000, all fluids ordered (2750 mL) are completely infused, which is greater than the target volume. Therefore,

1000 would not reflect the end time of the target ordered volume.

Question 91: **Slide 40. Using this example, on a Clinical Data Abstraction Center (CDAC) review, I was told the one-hour time frame would be from 0919 to 1019. This affected the outcome for the reviewed case since there was a low BP at the exact time the bolus was completed, which I counted and the CDAC did not. What is the right time frame?**

The example on slides 38–40 is specifically for purposes of the presentation. It is not an example from an actual medical record. Therefore, the completion time of the target ordered volume and the one hour to assess for *Persistent Hypotension* will be dependent upon the target ordered volume required and the fluids ordered and infused.

Question 92: **The physician orders for 30 mL/kg bolus for 1803 mL over one hour were initiated at 0253, but there is not a weight in the order. The weight that is documented closest to and before the crystalloid fluid order is 61 kg, so 1830 mL are needed. There is another bolus of 1000 mL from 0507–0539. Would we use only the 30 mL/kg bolus and look for *Persistent Hypotension* between 0539 and 0639, or would we use the second bolus for the extra 27 mL and look for *Persistent Hypotension* between 0508 and 0608?**

All crystalloid fluids ordered and started within the six hours prior to three hours after *Initial Hypotension* or *Septic Shock Present* would be used. Therefore, if the 1000 mL fluid bolus was ordered and started within the specified time frame, these fluids would be used. If the 1000 mL fluid bolus that was started at 0507 was ordered and started within the specified time frame, the hour to assess for *Persistent Hypotension* would be 0508 to 0608.

Question 93: **For *Persistent Hypotension*, the nurse charts the time the infusion is completed but, in our electronic health record (EHR), it only shows in the computer under "Infusion and Medical Billing Summary." I currently do not have access to this module. Should I get access or use the rate that is ordered to calculate the infusion stop time?**

If the infusion completed time is not available, the ordered rate would be used to determine the infusion completion time.

Question 94: **If there aren't two BP readings within the hour after the infusion is**

complete, would we answer "No" to *Persistent Hypotension*? Would this pass the measure even though there could be quality issues if the vital signs were not taken and recorded as necessary (e.g., subsequent hypotensive BPs beyond one hour)?

For determining *Persistent Hypotension*, if only one reading is documented in the hour to assess for *Persistent Hypotension* and that reading is hypotensive, value "3" (No or UTD) would be selected for *Persistent Hypotension*. If only one reading was documented and that reading was normal, value "2" (No) would be selected. Selecting value "2" (No) would allow the case to continue abstraction of the measure and selecting value "3" (No or UTD) would cause the case to fail the measure.

Question 95: **How do you determine if *Persistent Hypotension* is present if there are multiple BPs, both hypotensive and normotensive, within the hour following the completion of the target fluid volume?**

If there are more than two blood pressure readings within the hour, refer to the last two consecutive readings in the hour to determine if hypotension persists.

Question 96: **How do you answer the question for *Persistent Hypotension* assessed when the fluids complete during surgery and the vital signs are taken during surgery?**

Per the guidance, hypotensive readings obtained in the operating room (OR) would not be used. Therefore, if the patient is in the OR during the hour to assess for *Persistent Hypotension* and blood pressure readings are documented, value "2" (No) would be selected for *Persistent Hypotension*.

Repeat Volume Status and Tissue Perfusion Assessment Performed

Question 97: **Slide 42. If the physician notes the "Review of systems" statement and also lists the elements, which do you abstract?**

With multiple *Repeat Volume Status and Tissue Perfusion Assessments Performed*, abstract the date and time of the latest assessment documented within the appropriate time window.

Question 98: **Slide 42. Would the documentation of "review of systems" suffice or**

does it need to say, "review of systems complete"?

The physician/APN/PA documentation attesting to performing a "review of systems" or stating "review of systems complete" would suffice.

Question 99: **Slide 43. How is the documentation of "Review of systems negative except as noted in H&P" acceptable, as it says nothing about sepsis or reperfusion? This requires further clarification.**

The allowance for physician/APN/PA documentation attesting to performing an exam within the *Repeat Volume Status and Tissue Perfusion Assessments Performed* data element does not require a reference to sepsis or reperfusion. For physician/APN/PA documentation to suffice for the attestation allowance in this data element, the documentation must simply reflect the physician/APN/PA performance of an exam. The attestation guidance and acceptable options were incorporated based on input from clinicians reflecting actual clinical practice indicating an examination assessing perfusion status was completed.

Question 100: **Slide 43. Are you required to check the history and physical (H&P)?**

Physician/APN/PA documentation for *Repeat Volume Status and Tissue Perfusion Assessment Performed* can be used from any section of the medical record as long as it meets the guidance in the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. In this case, checking the H&P is not necessary because the physician/APN/PA documentation "Review of systems negative except as noted in H&P" is acceptable for physician/APN/PA documentation attesting to performing an exam.

Question 101: **Slide 43. Can you provide further guidance on acceptable documentation of this assessment since there is a lot of confusion and the poll responses were approximately 50/50?**

Some examples of acceptable physician/APN/PA documentation attesting to performing an exam include:

- "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."
- "I have reassessed the patient's hemodynamic status."

Question 102: **If a patient doesn't have a central line, would a venous blood gas count as a reassessment?**

No, if documentation, such as peripheral venous blood gas, indicates the oxygen saturation is not from a central line, do not use it.

Question 103: **The physician notes, "At least 10 organ systems reviewed and negative except as indicated." Is this acceptable for tissue perfusion assessment? My concern is that they note "at least 10 organ systems."**

Yes, the physician/APN/PA documentation attesting to a review of systems or "systems review" would be acceptable.

Question 104: **Would an H&P within the time frame count as a repeat volume status exam?**

Simply the documentation of an H&P within the specified time frame would not suffice for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. If there is physician/APN/PA documentation within the H&P attesting to performing an exam or documentation sufficing five of the eight parameters provided within the data element, then the documentation within the H&P may be used to meet the data element criteria.

Question 105: **Do the five out of eight criteria for reassessment need to be contained within the same note, or can three be found in one physician's note and two in another, all within the same time frame?**

Per the data element, the parameters do not need to all be contained within the same physician/APN/PA documentation. As long as five of the eight parameters are documented by the physician/APN/PA within the specified time frame, value "1" (Yes) would be selected.

Question 106: **For repeat volume status, would it suffice if the physician documents two liters fluids given and the patient remains hemodynamically stable within the specified time frame? In the required time frame, would the**

statement "Severe sepsis with normal BP responding to fluids" meet the requirements?

The physician/APN/PA documentation "patient remains hemodynamically stable" is acceptable for physician/APN/PA documentation attesting to performing an exam because the term "hemodynamically stable" indicates that more than just blood pressure was assessed and it is consistent with examples in the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. The physician/APN/PA documentation "Severe sepsis with normal BP responding to fluids" would not suffice for physician/APN/PA documentation attesting to performing an exam.

Question 107: **Why doesn't a physical examination completed by system and documented within the specified time frame meet the volume reassessment requirement but a simple statement stating, "Review of systems complete." without documentation by system does meet the requirement?**

Option one in the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element is looking for physician/APN/PA documentation indicating or attesting to performing or completing a physical examination. Therefore, to suffice option one in the data element, the physician/APN/PA documentation must attest to performing the exam. The documented findings of a physical exam can be used to suffice the second option which includes documentation of five of the eight parameters provided in the data element.

Question 108: **If a provider documents all required vital signs, skin color, capillary refill, cardiopulmonary assessment, and peripheral pulses in the physical exam portion of the H&P, can we use that as our reassessment exam time?**

Yes, the date and time of the physician/APN/PA documentation of five of the eight parameters would be acceptable for the *Repeat Volume Status and Tissue Perfusion Assessment Performed Date* and *Time*.

Question 109: **Is it acceptable if an H&P is done within the time frame and states "This is also an assessment of the perfusion"?**

Yes, the physician/APN/PA documentation stating "this is also an assessment of the perfusion" within the specified time frame would be

acceptable for physician/APN/PA documentation attesting to performing an exam.

Question 110: **It is notable and concerning that attendees (and abstractors) continue to be confused regarding the perfusion exam element.**

Thank you for the comments. We will continue addressing points of confusion within the measure through the SEP-1 webinars.

Severe Sepsis Present

Question 111: **Slide 45. There is documentation within the specified time frame that the patient has end-stage renal disease (ESRD), is on dialysis, has acute on chronic renal failure, and elevated creatinine. Should the creatinine be used for organ dysfunction?**

The scenario in this question represents a situation not specifically addressed in slide 45 or in the specifications manual: The patient has an elevated creatinine, has ESRD, is on dialysis, and has documentation of acute on chronic renal failure. In a situation like this, the guidance should be considered as a whole. Whether or not a baseline creatinine is documented, the guidance for a dialysis patient with ESRD (which indicates that all reported creatinine levels should be disregarded) should be followed. The reason is, regardless if the patient has acute on chronic renal failure potentially causing an elevated creatinine above the patient's baseline value, there is also guidance that applies to this patient case to disregard all reported creatinine levels.

Question 112: **Slide 45. If the patient has a documented baseline creatinine of 0.5, then a creatinine of 1.7, and the physician documents acute kidney injury (AKI), should the creatinine of 1.7 be used, even though it is less than 2.0?**

No, to use an elevated creatinine as evidence of organ dysfunction, the creatinine value must be greater than 2.0.

Question 113: **Slide 45. If there is documentation of chronic kidney disease (CKD) with baseline creatinine of 1.9 to 2.3, which creatinine levels would be excluded and why?**

With a documented creatinine baseline of 1.9 to 2.3 and documentation of CKD, creatinine values within 0.5 of 2.3 would not be used as evidence of organ dysfunction. Since the physician/APN/PA indicated the creatinine of 2.3 is "normal for the patient" (baseline), the guidance allows for creatinine values within 0.5 above the documented baseline to not be used.

Question 114: **Slide 45. The patient has ESRD and is on hemodialysis; however, the baseline creatinine is documented and the current creatinine is greater than 0.5 above their baseline. Which takes precedence?**

Do we abstract based off of the baseline, or do we disregard the value based off of ESRD and dialysis?

If there is documentation the patient has ESRD and is on hemodialysis, guidance for physician/APN/PA documentation of ESRD and hemodialysis in the *Severe Sepsis Present* data element for creatinine greater than 2.0 (which indicates all reported creatinine levels should be disregarded as a sign of organ dysfunction) should be followed.

Question 115: **Slide 45. If the baseline creatinine is documented as 1.0 and the creatinine result is 1.9, would that be used to determine organ dysfunction or does the threshold creatinine of greater than 2.0 need to be met?**

No, to use an elevated creatinine as evidence of organ dysfunction, the creatinine value must be greater than 2.0.

Question 116: **Slide 47. Can you provide rationale as to why SIRS criteria or organ dysfunction only in the OR is excluded when anesthesia is used in other areas (e.g., catheterization lab, endoscopy)?**

Initially, SIRS criteria and evidence of organ dysfunction documented in the OR were disregarded due to the likelihood that surgery and medications used during surgery may result in these values being abnormal. Specifications manual v5.6 (discharges July 1–December 31, 2019) has been updated to include other areas of the hospital, including interventional radiology, during active delivery, or procedural/conscious sedation, in which criteria would not be used if met in those areas.

Question 117: **Slide 47. Do the SIRS criteria in the OR also include preoperative and**

post-anesthesia care unit (PACU) areas?

No, the guidance provided on slide 47 states SIRS criteria or a sign of organ dysfunction obtained within the OR should not be used.

Question 118: **Slide 48. To clarify, can any late entry for documentation clarification be used? Does this mean that you would not be able to use any physician "queries" to clarify the severe sepsis elements that are answered after discharge? Medicare allows for these types of clarifications or corrections. If the date/time is in the corrected documentation, are you saying we cannot use this?**

Correct, any documentation of an infection, severe sepsis, or septic shock documented after the time of discharge would not be used. Since determining the *Severe Sepsis or Septic Shock Presentation Time* is critical, documentation of an infection, severe sepsis, or septic shock after discharge would not be used as this often causes an inaccurate presentation time.

Question 119: **Slide 48. Have the criteria changed to allow registered nurses to document infection? Aren't physicians the only ones that can diagnose or provide that type of diagnosis?**

No, the criteria have not changed. Physician/APN/PA or nursing documentation referencing the presence of an infection is acceptable. This guidance is for the purpose of identifying the presence of an infection for the measure only, not for the purpose of establishing a clinical diagnosis of an infection.

Question 120: **Slide 49. Are addendums to documentation allowed to clarify the presence of severe sepsis within 30 days of discharge as per the Medicare Conditions of Participation?**

Late entries and addendums are acceptable within 30 days after discharge unless otherwise stated within a data element. The Introduction to the Data Dictionary, within the specifications manual, provides specific guidance for medical record documentation and the use of late entries and addendums.

Question 121: **Slide 49. If severe sepsis or shock is clarified in a coding query while the patient is still in the hospital, would you be able to use that documentation or time?**

Yes, as long as the documentation of severe sepsis within the coding query is physician/APN/PA documentation, it is acceptable to use for establishing the presence of severe sepsis.

Question 122: **Slide 49. Would a discharge note or addendum after discharge with documentation of "no severe sepsis present" exclude a case?**

If the physician/APN/PA documentation indicating severe sepsis is not present within six hours after the *Severe Sepsis Presentation Time*, it would be used to select value "2" (No) for *Severe Sepsis Present*.

Question 123: **Slide 50. If the lab report states that the results were phoned at 1600, could you use that documentation for the time?**

If the documentation is in a narrative note that is directly associated with the laboratory test value, this would not be considered a primary source (lab test value result time from lab); it would be considered a supporting source for determining the time of a laboratory test result. Therefore, this time would only be used if a laboratory test value result time is unavailable.

Question 124: **Slide 51. I thought we used collected time for labs. If the lactate of greater than 2.0 is the only organ criteria, would we use the result time? If it is the initial lactate, would we use the collected time? Please explain.**

For establishing the presence of severe sepsis with SIRS criteria or evidence of organ dysfunction, the laboratory result time is used. For determining the *Initial Lactate Level Collection*, the collection time of the lab is used.

Question 125: **Slide 51. The lactate was drawn at 1700 and resulted at 1720 with a level of 2.7. There is no other documentation. Which time is used for organ dysfunction?**

The priority order guidance applies when there is more than one time documented and each is associated with the laboratory test result. The situation in this question provides a lactate draw time and a lactate resulted time. Because the guidance indicates to use laboratory test value result times, the lactate result time of 1720 would be used for establishing evidence of organ dysfunction for *Severe Sepsis Present*.

Question 126: **Slide 51. Does the lab priority order include blood cultures?**

No, the *Blood Culture Collection Date* and *Time* data elements provide specific guidance for determining the date and time of *Blood Culture Collection*.

Question 127: **Slide 51. Our lab reports will have a note with the time an alert value is called and a resulted time. Should we use the resulted time or the "call" time noted in the lab report?**

If the laboratory test value result time is available, this time would be used. Only if the laboratory test value result time is not available would the secondary source, within narrative documentation, be used.

Question 128: **Slide 52. Why would "B" (PA notes - LA 2.5 at 0750) be the correct answer? According to the priority list, the flow sheet would be second and the PA note would be last. Additionally, slide 34 lists the priority of a non-narrative location ahead of a narrative location.**

First, slide 34 provides the guidance for abstracting the *Initial Lactate Level Collection*. Therefore, the guidance on slide 34 would not apply to determining the time of the *Severe Sepsis Present* clinical criteria.

Second, "B" was selected for the question on slide 52 because it reflects a time within a narrative note that is directly associated with the laboratory test value. Therefore, this would be the first option under the secondary sources for determining the time of a lab result. The lactate result documented on the Sepsis Flowsheet listed as "D" on slide 52 would reflect number two under the secondary sources.

Question 129: **Slide 52. Is the "Sepsis Flowsheet" within a PowerChart?**

Slide 52 presents a general example scenario and does not specify the location of the "Sepsis Flowsheet." The location of the "Sepsis Flowsheet" does not matter as long as it is in the patient's medical record.

Question 130: **Slide 53. Do you need a baseline creatinine, as per slide 45, to determine if an elevated value for a CKD patient should be used?**

The guidance on slide 45 indicates that a creatinine greater than 0.5 above the documented baseline should not be used when there is also documentation of chronic kidney disease. Slide 53 addresses a frequently asked question (FAQ) that is related to physician/APN/PA documentation that an elevated creatinine value is due to a chronic condition. If there is physician/APN/PA documentation indicating the elevated creatinine is due to chronic kidney disease, the elevated creatinine would not be used.

Question 131: **Slide 53. By definition, a chronic condition of kidney disease is an elevated creatinine or glomerular filtration rate. CKD stage III has specific guidelines. Wouldn't we need to go by those guidelines?**

No, for purposes of the SEP-1 measure, the *Severe Sepsis Present* data element provides the guidelines for using an elevated creatinine as evidence of organ dysfunction.

Question 132: **Slide 54. When excluding for SIRS or organ dysfunction criteria based on physician documentation of a normal value for that patient, is documentation needed for each individual value or is a onetime documentation acceptable?**

Physician/APN/PA documentation determines which values would not be used. For example, if the physician/APN/PA documentation stated "80/50 normal for patient," the systolic BP of 80 and less severe values (80–89) would not be used. If the physician/APN/PA documentation stated, "hypotension normal for the patient," all hypotensive readings would not be used.

Question 133: **Slide 54. What is the definition of "same documentation"? Is it in the same note or same sentence?**

The guidance on slide 54 referring to the "same documentation" generally reflects documentation must be within the same sentence or paragraph. Since the guidance also states inferences should not be made, the physician/APN/PA documentation indicating the criteria is normal for the patient, due to a chronic condition, or due to a medication would need to be in the same sentence or paragraph.

Question 134: **Slide 55. Should the answer be "Yes," you would not use the elevated bilirubin, because of the use of the double negative in the question?**

For the question and answer on slide 55, the elevated bilirubin would be used because documentation of the chronic condition alone does not indicate it is causing or associated with the elevated bilirubin. You would not use the elevated bilirubin, if there was physician/APN/PA documentation that the elevated bilirubin was due to a chronic condition (e.g., cirrhosis).

Question 135: **Slide 57. If the physician documents that the 4.3 lactate acid is related to seizures, would we use that as a sign of organ dysfunction because the physician did not specifically document that it was not related to an infection or sepsis?**

Yes, documentation attributing the elevated lactate to an acute condition such as "seizures" would allow the elevated lactate to still be used. To not use the elevated lactate in this scenario, further physician/APN/PA documentation attributing the acute condition (seizure on slide 57) to a non-infectious source would be required.

Question 136: **Slide 57. It states to use "AKI, dehydration, creatinine 3.8" for organ dysfunction. However, on slide 58, it states not to use "AKI with creatinine 3.8" and "Poor PO intake x 3 days leading to AKI at this point." Dehydration can be due to poor PO intake for three days. Must it specifically state that the dehydration is caused by an infection? Physicians usually do not document this. Can you explain the differences for these two slides?**

Slide 57 provides guidance and examples reflecting physician/APN/PA documentation attributing the sign of organ dysfunction to an acute condition. In the example "AKI, dehydration, creatinine 3.8," the elevated creatinine is documented with two acute conditions. The elevated creatinine would be used as a sign of organ dysfunction because the acute conditions could be caused by an infection or severe sepsis.

Slide 58 provides guidance and an example which attributes the elevated creatinine to an acute condition ("AKI"). Then, further documentation attributes the acute condition ("AKI") to a non-infectious source ("Poor PO intake x 3 days leading to AKI at this point"). In this case, the elevated creatinine should not be used as a sign of organ dysfunction because the acute condition is identified as due to a non-infectious source.

Physician/APN/PA documentation is not required to attribute the acute condition to an infection to use the sign of organ dysfunction. Rather, if the

physician/APN/PA documentation attributes the sign of organ dysfunction to an acute condition and the acute condition is attributed to a non-infectious source, then the sign of organ dysfunction would not be used.

Question 137: **Slide 57. How would you abstract if there is documentation that the creatinine related to CKD was 2.8 and "Cr. 2.1, acute on chronic renal failure related to urinary tract infection" thereafter?**

In this scenario, the use of the elevated creatinine depends on how the documentation is presented in the medical record. If this conflicting documentation is within the same documentation, the elevated creatinine would be used. If the conflicting documentation is in two or more separate pieces of documentation, the latest documentation within the 24 hours after the *Severe Sepsis Presentation Time* would be used to determine if the elevated creatinine would be used or not.

Question 138: **Slide 57. Is "history of" considered the same as chronic? One can have a history of a condition that is not necessarily chronic.**

This would depend on the specific documentation within the medical record. However, most often SIRS criteria or a sign of organ dysfunction would not be used when documented as due to a condition which is identified as a "history of" for the patient.

Question 139: **Slide 58. How would you abstract if the physician only documents that the condition may be due to a non-infectious process? For example, the physician documents, "Lactate may be elevated due to Metformin use."**

Physician/APN/PA documentation that the SIRS criteria or sign of organ dysfunction is normal for the patient, due to a chronic condition, or due to a medication would not be used. For the example "Lactate may be elevated due to Metformin use," the elevated lactate level would not be used as the physician documentation attributes the elevated lactate to the medication. When documented this way, further documentation regarding a non-infectious source is not required. Only when the SIRS criteria or sign of organ dysfunction is documented as due to an acute condition would the acute condition then need to be documented as due to a non-infectious source.

Question 140: **Slide 60. If the physician documents "Thrombocytopenia related to chemotherapy," would we not use all platelet counts less than 100,000? If the physician documents "low plates due to chemotherapy," with no mention of the level, would we disregard all platelet counts? Would we also not use any heart rates above 90 if the tachycardia is due to medications?**

If the physician documented "Thrombocytopenia related to chemotherapy," all platelet values less than 100,000 would not be used, because the term thrombocytopenia is defined by a platelet count less than 100,000.

If the physician documented "low platelets due to chemotherapy," with no mention of the level, all low platelet counts, less than 100,000, would not be used, because of the broad reference of low platelets being due to the chemotherapy.

If a physician documents that "tachycardia is due to medications" then all heart rates above 90 would not be used, because tachycardia is defined by an elevated heart rate.

Question 141: **Slide 60. Could you explain why platelet counts greater than or equal to 75,000 would not be used?**

Slide 60 provides physician/APN/PA documentation that the platelet count of 75 is due to the medication, and less severe platelet counts would also not be used. In this example, less severe platelet counts would reflect platelets between 75 to 99. The medication would be considered the cause of these less severe platelet counts, as the medication was documented as causing the platelet count of 75.

Question 142: **Slide 60. How do we abstract the white blood counts (WBC) and platelets if the physician documents "neutropenia secondary to chemotherapy? Rule out infection verses neutropenic fever. "**

With conflicting documentation regarding the use of the WBC within the same documentation, the WBC would be used based on the following guidance:

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.

Question 143: **Slide 61. Variation in heart rates of five beats per minute is normal. Going from 110 to 115 is likely insignificant, as it falls well within a normal range for a patient. Will CMS revisit this?**

The medical record, including the documented heart rates, should be abstracted at face value. If there is physician/APN/PA documentation indicating an elevated heart rate is "normal for the patient," then the elevated heart rate(s) would not be used. We appreciate your comment and will take it into consideration.

Question 144: **Slide 62. When can tachycardia be used?**

Documentation of a term that represents or defines a SIRS criterion or sign of organ dysfunction is only used when there is physician/APN/PA documentation that the term defining the abnormal SIRS criterion or sign of organ dysfunction is normal for the patient, due to a chronic condition, or due to medication.

To suffice the criteria of the *Severe Sepsis Present* data element, the actual value(s) of the SIRS criteria or sign of organ dysfunction are required. A term that represents or defines SIRS criteria or sign of organ dysfunction would not be used to meet the clinical criteria of the *Severe Sepsis Present* data element.

Question 145: **Slide 63. If the physician documents "pancytopenia r/t chemo," does this cover WBCs less than 4,000 and platelets less than 100,000 if the resulted lab values are not specifically documented in a note within the time frame?**

Yes, the physician/APN/PA documentation of "pancytopenia r/t chemo" would allow WBCs less than 4000 and platelets less than 100 to not be used since the term "pancytopenia" represents or defines the abnormal values.

Question 146: **Slide 63. What time frame for documentation does this refer to?**

The time frame for physician/APN/PA documentation considering SIRS

criteria or a sign of organ dysfunction as normal for the patient, due to a chronic condition, or due to medication is prior to or within 24 hours after the *Severe Sepsis Presentation Time*.

Question 147: **Slide 63. Doesn't all documentation of atrial fibrillation (A-fib) exclude the heart rate (HR) from SIRS criteria? For example, is a documented history of A-fib, no documentation of tachycardia, and a HR of 97 at 1300, considered SIRS criteria? What about "history of A-fib, in A-fib now"?**

The documentation of "A-fib" alone would not exclude elevated heart rates from being used as SIRS criteria. To not use the elevated heart rates as SIRS criteria, the elevated heart rates would need to be documented by the physician/APN/PA as normal for the patient, due to a chronic condition, due to medication, or due to an acute condition with a non-infectious source.

If "history of A-fib" or "history of A-fib, in A-fib now" is documented, the elevated heart rates would be used. For example, with documentation of "history of A-fib, A-fib with tachycardia," the elevated heart rates would not be used as this documentation attributes the tachycardia to A-fib which is considered chronic for the patient based on the documentation of "history of A-fib."

Question 148: **Slide 63. Must the A-fib with rapid ventricular response (RVR) be identified specifically as chronic to exclude the elevated heart rate? I have seen patients who have A-fib with RVR on anti-arrhythmic drugs.**

Yes, A-fib would need to be documented as a chronic condition or "history of." We would not infer that A-fib is a chronic condition based on an anti-arrhythmic medication alone.

Question 149: **Slide 63. Does the documentation need to specifically state the parameters? For example, physicians may define hypotension differently; some may define it as systolic BP less than 100 instead of less than 90.**

No, the documentation is not required to specifically state the parameters. Physician/APN/PA documentation may consider the specific BP value or a term that represents or defines the abnormal BP value (e.g. hypotension) as normal for the patient, due to a chronic condition, or due to medication. For

the measure and most definitions, hypotension is a systolic BP reading less than 90.

Question 150: **Slide 63. Would we still use tachycardia if it was related to medications? What if this was a one-time medication with a short half-life, like epinephrine? At what point could we use another tachycardic value if the medications that caused the initial tachycardia had a short half-life or were only given once?**

If the physician/APN/PA documentation attributed the tachycardia to a medication, the elevated heart rates would not be used. The elevated heart rates would then only be used if there was further physician/APN/PA documentation attributing the elevated heart rates to an infection or severe sepsis.

Question 151: **Slide 63. Is an actual value required for criteria or is a term like "tachycardia" acceptable? We rarely have physicians that document exact numbers or values; they typically document things like "elevated HR related to meth use."**

Documentation of a term that represents or defines a SIRS criterion or sign of organ dysfunction is only acceptable when there is physician/APN/PA documentation that the term defining the abnormal SIRS criterion or sign of organ dysfunction is normal for the patient or due to a chronic condition or medication.

To suffice the criteria of the *Severe Sepsis Present* data element, the actual value(s) of the SIRS criteria or sign of organ dysfunction are required. A term that represents or defines SIRS criteria or sign of organ dysfunction would not be used to meet the clinical criteria of the *Severe Sepsis Present* data element.

Question 152: **Slide 63. If the physician documented "hypotension in the field" but there is no documentation of low BPs in the emergency management system (EMS) record, do we still use the physician documentation of hypotension as organ dysfunction?**

No, the documentation of "hypotension in the field" would not be used. Documentation of a term that represents or defines a SIRS criterion or sign of organ dysfunction is only acceptable when there is physician/APN/PA

documentation that the term defining the abnormal SIRS criterion or sign of organ dysfunction is normal for the patient or due to a chronic condition or medication.

To suffice the criteria of the *Severe Sepsis Present* data element, the actual value(s) of the SIRS criteria or sign of organ dysfunction are required. A term that represents or defines SIRS criteria or sign of organ dysfunction would not be used to meet the clinical criteria of the *Severe Sepsis Present* data element.

Question 153: **Slide 63. For tachycardia, it states that the HR must be greater than 100. Is a HR greater than 90 no longer acceptable?**

For meeting SIRS criteria for the *Severe Sepsis Present* data element, heart rates greater than 90 are acceptable. The inclusion of "Heart rate >100" in the guidance reflected on slide 63 is erroneous and should reflect "Heart rate >90." This has been updated in version 5.6 of the specifications manual.

Question 154: **Slide 64. Can all of the answers be used for SIRS criteria? If no, why not?**

No, the answers on slide 64 would not be used to meet SIRS criteria for the *Severe Sepsis Present* data element. To suffice the criteria of the *Severe Sepsis Present* data element, the actual value(s) of the SIRS criteria or sign of organ dysfunction are required. A term that represents or defines SIRS criteria or sign of organ dysfunction would not be used to meet the clinical criteria of the *Severe Sepsis Present* data element. Documentation of a term that represents or defines a SIRS criterion or sign of organ dysfunction is only acceptable when there is physician/APN/PA documentation that the term defining the abnormal SIRS criterion or sign of organ dysfunction is normal for the patient or due to a chronic condition or medication.

Question 155: **Slide 64. Does a history of A-fib negate all elevated HRs even if it is not noted in the A-fib documentation?**

The documentation of "A-fib" alone would not exclude elevated heart rates from being used as SIRS criteria. To not use the elevated heart rates as SIRS criteria, the elevated heart rates would need to be documented by the physician/APN/PA as normal for the patient, due to a chronic condition, due to medication, or due to an acute condition with a non-infectious source. If

"history of A-fib" or "history of A-fib, in A-fib now" is documented, the elevated heart rates would be used. For example, if "history of A-fib, A-fib with tachycardia" is documented, the elevated heart rates would not be used as this documentation attributes the tachycardia to A-fib which is considered chronic for the patient based on the documentation of "history of A-fib."

Question 156: **Slide 64. To exclude the pulse for SIRS, does previous A-fib need to be listed on the patient's history? Does RVR or tachycardia need to be listed also?**

To not use the elevated heart rate, the physician/APN/PA documentation must attribute the elevated heart rate to A-fib (e.g. "A-fib with tachycardia" or "A-fib with RVR") and the condition must be a chronic condition. With "A-fib with tachycardia" or "A-fib with RVR" documented and "history of A-fib" documented, this documentation would conclude that the elevated heart rates are due to a chronic condition.

Question 157: **Slide 64. Does the history of A-fib and A-fib with tachycardia need to be in the same note or, to exclude the HR, can the history of A-fib be documented in the medical history section and the A-fib with tachycardia be documented in the impression section?**

The physician/APN/PA documentation considering the elevated heart rate is due to A-fib must be in the same documentation (e.g. "A-fib with tachycardia"). However, further documentation considering A-fib as a chronic condition is not required within this same documentation, but it must be documented prior to or within the 24 hours after the *Severe Sepsis Presentation Time*.

Question 158: **Slide 64. Controlled, chronic A-fib can become uncontrolled in the presence of sepsis. Therefore, shouldn't the elevated heart rate, even with a history of chronic A-fib, be used as SIRS criteria?**

If the physician/APN/PA documentation attributes the elevated heart rate to a chronic condition, the elevated heart rate would not be used unless there was further documentation considering the elevated heart rate is due to an infection or severe sepsis.

Question 159: **Slide 66. If the physician documents SIRS due to a noninfectious source, then documents an infection such as a urinary tract infection (UTI),**

would you disregard all SIRS criteria?

To not use SIRS criteria or a sign of organ dysfunction, the physician/APN/PA documentation must indicate the criteria is normal for the patient, due to a chronic condition, due to medication, or due to an acute condition with further documentation of a non-infectious source. The documentation of "SIRS due to non-infectious source" would not exclude the SIRS criteria from being used. To not use the SIRS criteria, the criterion would need to be documented as due to an acute condition and the acute condition documented as due to a non-infectious source.

If there was physician/APN/PA documentation attributing a SIRS criterion to an acute condition with a non-infectious source and due to an infection within the same documentation, the SIRS criterion would be used.

Question 160: **Slide 66. If the physician documents "query pneumonia," is that considered a negative qualifier?**

Yes, since "query pneumonia" generally reflects "questionable pneumonia," this would be a negative qualifier and not used to suffice criteria A for *Severe Sepsis Present*.

Question 161: **Slide 66. Why is any diagnosis included in the "Differential Diagnosis" as a positive qualifier? This could include many potential diagnoses potentially unrelated to infection.**

As noted in the question, a differential diagnosis is generally considered a list of possible or potential diagnoses. As such, each condition is considered possible until ruled out. For the *Severe Sepsis Present* clinical criteria A, documentation of a suspected or possible infection is acceptable. The measure stewards, therefore, indicated that a differential diagnosis of an infection should be considered a positive qualifier.

Question 162: **Slide 66. If a blood culture order has a set question of "R/O Sepsis?" built in with an answer of "Yes," can this be used as documentation of infection?**

Yes, this would suffice *Severe Sepsis Present* criteria A as long as it is physician/APN/PA or nursing documentation.

Question 163: **Slide 66. If the physician documents "monitor for signs of septic shock," would the documentation of "monitor" be used as a negative or positive qualifier?**

The documentation "monitor for signs of septic shock" would be a negative qualifier as this would not reflect documentation indicating septic shock is currently present or suspected.

Question 164: **Slide 66. Why can't documentation containing both a positive and negative qualifier be used?**

Documentation that includes a positive and a negative qualifier is often unclear regarding the presence of the condition. For example, it is difficult to determine if pneumonia is present or suspected if the documentation reflected "possible pneumonia but unlikely." Therefore, this documentation would not be used to consider pneumonia present or suspected, and review of the medical record would continue for further documentation of an infection.

Question 165: **Slide 66. Does a patient have severe sepsis if a differential diagnosis of severe sepsis is used for *Severe Sepsis Presentation Time* and, within a qualified time period, the same provider notes severe sepsis was ruled out? The guidance is conflicting. The guidance says if a positive and a negative qualifier are used, then the data should not be used. The guidance also says a negative qualifier used after a positive qualifier should not cancel the data.**

The last sentence in the bullet point, on slide 66, states, "Documentation containing both a positive and negative qualifier should not be used to meet criteria." This is in reference to a single piece of documentation that includes both a positive and negative qualifier. For example, a note that states "possible pneumonia but unlikely" contains both a positive and negative qualifier in the same statement documented at the same time. In this case, the documentation is not sufficient either way and should be disregarded.

Further guidance within the *Severe Sepsis Present* data element is provided to address situations where positive and negative qualifiers are documented in different notes and different times. This guidance indicates that if *Severe Sepsis* was documented and within six hours after the *Severe Sepsis Presentation Time* there is physician/APN/PA documentation indicating the

patient does not have severe sepsis, then value "2" (No) would be selected for *Severe Sepsis Present*.

Question 166: **For severe sepsis, we must have a source, and the diagnosis of sepsis does not meet this requirement. However, sepsis is on the inclusion list of words that count for infection. Is this not contradictory? How does this work?**

There is not sufficient information in this question to provide an accurate response. Please submit the question with more detail via the online Q&A tool available on *QualityNet.org*.

Question 167: **Are "Acute Sepsis" and "Severe Sepsis" synonymous?**

No, for the *Severe Sepsis Present* data element, the documentation of "acute sepsis" would only suffice criteria A (infection).

Question 168: **Would the ED nurse's documentation of "Patient states I think I have an infection" be considered documentation of infection or should the infection/suspected infection be documented as an assessment by a physician or equivalent?**

Yes, the nursing documentation of a possible or suspected infection would suffice *Severe Sepsis Present* criteria A (infection).

Question 169: **Infection and organ dysfunction are both documented during an ED visit. The two SIRS criteria are not identified until eight hours later. Do we then "start over" and look for infection and organ dysfunction? If the original infection is documented again (e.g., in a progress note), can we still use that as the infection? What if the provider documents that sepsis is ruled out, but it isn't documented for a day or two after severe sepsis is suspected?**

If an infection and sign of organ dysfunction are documented and two SIRS criteria are not documented within six hours, review of the medical record would continue to determine if all three clinical criteria were met within six hours of each other. Further documentation of an infection within the medical record that is within six hours of the other severe sepsis clinical criteria would be acceptable for criteria A. Physician/APN/PA documentation of "sepsis ruled out" greater than six hours after the *Severe*

Sepsis Presentation Time would not be used.

Question 170: **If the elevated lactate is used as organ dysfunction to meet criteria, would you still use the highest one as the presentation time?**

No, using the highest lactate level result when multiple lactates are collected only applies to the *Initial Lactate Level Collection* data element.

Question 171: **Is triage nurse documentation that states a patient has been diagnosed with a UTI by their primary care practitioner and has been taking antibiotics for it acceptable for the infection criteria or is other proof (e.g., home medication list, the last dose of antibiotic taken) needed?**

The nursing documentation of the infection would suffice *Severe Sepsis Present* criteria A without need of further home medications or last dose of antibiotics.

Question 172: **Are we able to use nursing documentation of dialysis prior to or within 24 hours following *Severe Sepsis Present*?**

Per the guidance regarding documentation of ESRD and hemodialysis or peritoneal dialysis, physician/APN/PA documentation prior to or within 24 hours after the *Severe Sepsis Presentation Time* is required to not use the elevated creatinine values. Nursing documentation of dialysis would not be acceptable.

Question 173: **If a patient presents to the ED and the ED physician does not diagnose severe sepsis, would the answer be "Yes" or "No" to *Severe Sepsis Present* if the attending physician on discharge two days later diagnoses sepsis and the patient meets criteria upon review of documentation in the ED?**

In this scenario, if all three severe sepsis clinical criteria were met within six hours of each other in the ED, the value "1" (Yes) would be selected for *Severe Sepsis Present*.

Question 174: **This question was posed to *QualityNet*:**

The patient started on an antibiotic with a stated infection in the order.

The patient does not meet severe sepsis criteria. When reviewing the remainder of the chart, would each administration of that antibiotic count as a source of infection to determine the presence of severe sepsis?

Yes. One must look at the original order history to see the time and date of the infection documentation.

Why would this count two, three, or four days later when the original documentation is several days earlier and this is just visible in the order history?

Per the guidance in the *Severe Sepsis Present* data element, 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 six hours of criteria b or c is acceptable (e.g., Levaquin is documented in MAR for pneumonia and nursing documentation within six hours of criteria b and c indicates a dose was given).

With the infection identified in the antibiotic order and the continued treatment of the infection evidenced by further administration of the antibiotic, the administration of the antibiotic would suffice for a continued source of possible infection.

Question 175: **When a physician documents that the patient is febrile, does that meet SIRS criteria? This is hard due to physicians calling 38.0 febrile, but our threshold for severe sepsis is greater than 38.3.**

No, the documentation of "febrile" would not suffice as SIRS criteria. Documentation of a term that represents or defines a SIRS criterion or sign of organ dysfunction is only acceptable when there is physician/APN/PA documentation that the term defining the abnormal SIRS criterion or sign of organ dysfunction is normal for the patient or due to a chronic condition or medication.

To suffice the criteria of the *Severe Sepsis Present* data element, the actual value(s) of the SIRS criteria or sign of organ dysfunction are required. A term that represents or defines SIRS criteria or sign of organ dysfunction would not be used to meet the clinical criteria of the *Severe Sepsis Present* data element.

Question 176: **How do I abstract the documentation "shock multi-factorial, includes possible sepsis and cardiogenic"?**

This documentation would suffice Severe Sepsis Present criteria A (infection). This documentation would not be used as physician/APN/PA documentation of septic shock.

Question 177: **What if the physician documents "pulmonary edema less likely pneumonia"? Can pneumonia still be a possible infection?**

This documentation includes a negative qualifier "less likely." Per the qualifiers table in the data element guidance, negative qualifiers should not be used to meet the criteria. Therefore, this would not be used to suffice *Severe Sepsis Present* criteria A (infection).

Question 178: **If UTI is part of a long list of differential diagnoses but the patient did not have a UTI, will the UTI be used as the source of infection?**

Yes, the documentation of "UTI" as a differential diagnosis would suffice *Severe Sepsis Present* criteria A unless there is further physician/APN/PA documentation within six hours indicating the patient does not have a "UTI."

Question 179: **If "concern for sepsis" is listed in the ambulance record, should this count as time of potential infection even though the hospital has not evaluated the patient?**

If "concern for sepsis" is documented by a physician/APN/PA or nurse, this documentation would suffice *Severe Sepsis Present* criteria A (infection).

Question 180: **Could a physician document in a way that negates meeting the three sepsis clinical criteria?**

If there is physician/APN/PA documentation within six hours after the *Severe Sepsis Presentation Time* (time all three clinical criteria were met) indicating the patient does not have sepsis or severe sepsis, then value "2" (No) would be selected for *Severe Sepsis Present*.

Question 181: **Would we be able to use the triage nurse documentation of "Brought in by EMS for sepsis alert" for infection time?**

Yes, this nursing documentation including "sepsis" would suffice *Severe Sepsis Present* criteria A.

Question 182: **If a patient has an elevated international normalized ratio (INR) of three and has warfarin listed as an active home medication, would you disregard the INR of three or does there need to be documentation of some kind by the provider stating, "Elevated INR due to warfarin prescription"?**

If an anticoagulant from Table 5.3 is documented as given or on the home medication record, the elevated INR value would not be used. Further physician/APN/PA documentation attributing the elevated INR value to the medication is not required.

Question 183: **Our ED physicians have been instructed to document "Patient is not septic at this time" or "Sepsis ruled out" if they do not believe the sepsis criteria are not related to sepsis. Would this allow the case to be excluded from the SEP-1 measure?**

If there is physician/APN/PA documentation within six hours after the *Severe Sepsis Presentation Time* (time all three clinical criteria were met) indicating the patient does not have sepsis or severe sepsis, then value "2" (No) would be selected for *Severe Sepsis Present*.

Severe Sepsis Presentation Date and Time

Question 184: **Slide 68. For determining severe sepsis presentation, are we to use documentation that occurs anywhere in the record prior to discharge of "severe sepsis present at admission" over clinical criteria being met?**

The physician/APN/PA documentation of "Severe Sepsis present at admission" may occur anywhere within the medical record. However, the earliest *Severe Sepsis Presentation Time* would be used. If the *Severe Sepsis Presentation Time* based on clinical criteria was earlier than the time the patient arrived to the floor/unit for admission, the time clinical criteria were met would be used for the *Severe Sepsis Presentation Time*.

Question 185: **Slide 68. Can you provide examples of acceptable documentation reflecting the arrival to floor time?**

Most often, the arrival to the floor or unit time is reflected in the documentation of the admit time to the floor/unit or documentation such as "admitted to room 4."

Question 186: **Slide 68. Can you provide examples of how you determine when the patient arrives to the unit? Our unit nurses do not document that specifically. Do we use the first documented vital signs, the admission assessment, or other documentation?**

Most often, the arrival to the floor or unit time is reflected in the documentation of the admit time to the floor/unit or documentation such as "admitted to room 4." Depending on the documentation, the admission assessment may provide documentation indicating a time of admission to the floor/unit. The vital signs would not suffice for documentation of the earliest time the patient arrived to the floor/unit for admission.

Question 187: **Slide 68. In our EMR, there is no way to document the specific time the patient arrives to the floor. What time should we use for "present on admission?" In our EHR, there is no way to document the specific time the patient arrives to the floor. Should we use the ED discharge time, the admission order time, the time the patient was assessed on the floor, or other documentation?**

Most often, the arrival to the floor or unit time is reflected in the documentation of the admit time to the floor/unit or documentation such as "admitted to room 4." Further documentation such as the ED discharge time, order for admission, or admission assessment would not be used unless the documentation indicated the time the patient arrived to the floor/unit for admission.

Question 188: **Slide 68. Is it acceptable if the physician documented severe sepsis present on arrival as opposed to admission?**

Yes, when severe sepsis is documented as "present on arrival," the arrival time to the ED or hospital is used for the *Severe Sepsis Presentation Time*.

Question 189: **Slide 68. The patient doesn't meet clinical criteria but the physician notes severe sepsis on admission. However, the patient has to board in the ED and the note is written prior to the patient's admission to the floor. Can we use the time that the ED documents that the patient needs to be boarded in the ED?**

If the physician/APN/PA documents "Severe Sepsis on admit," the earliest time of arrival to the floor/unit for admission would be used for the *Severe Sepsis Presentation Time*. The time the ED physician/APN/PA documents that the patient needs to be boarded would not be used.

Question 190: **Slide 68. If the patient is admitted, is the sepsis presentation time when the patient arrives to the floor or when all three criteria are met?**

Slide 68 provides guidance to use the earliest *Severe Sepsis Presentation Time* and guidance for abstracting the time when severe sepsis is documented as "present on admission." If there is physician/APN/PA documentation that "Severe sepsis was present on admission," the earliest time the patient arrived to the floor/unit for admission would be considered for the *Severe Sepsis Presentation Time*. However, if the patient met severe sepsis clinical criteria prior to the time the patient arrived to the floor/unit for admission, the earliest *Severe Sepsis Presentation Time* based on the clinical criteria would be used.

Question 191: **Slide 68. The ED physician documents severe sepsis present on admission. The note states that the patient meets criteria for severe sepsis, but there is no time associated with it. The note open time is 0900 and the admit time 0945. Which time would we use?**

If the documentation of both "Severe Sepsis present on admission" and "Severe Sepsis" are in the same note, the specified time "present on admission" (in this case, 0945) would be used to determine the *Severe Sepsis Presentation Time*.

Question 192: **Slide 69. Why isn't the admission order time correct? If "present on admission" was determined at 0900, why is the admit time 45 minutes later at 0945? The patient could potentially spend hours in the ED before being transferred to the floor.**

With the physician/APN/PA documentation of "Severe Sepsis present on admission," the earliest time the patient arrived to the floor or unit for admission is used as the literal "admission" time. The physician documentation of "present on admission" is abstracted at face value as a specified time for the presentation of severe sepsis. With this specified presentation time, other times such as the admission order time would not be used.

Question 193: **Slide 69. How can the PA document something before it actually happens?**

There is not sufficient information in this question to provide an accurate response. Please submit the question with more detail via the online Q&A tool available on *QualityNet.org*.

Question 194: **If the physician documents the specific time that the patient met criteria for severe sepsis, do I use that time or the clinical indicator time?**

The earliest *Severe Sepsis Presentation Time* would be used.

Question 195: **If a patient met criteria and/or the ED physician documented severe sepsis, would the ED physician note not qualify for presentation time?**

The earliest *Severe Sepsis Presentation Time* would be used. If the documentation of severe sepsis within the ED physician's note reflected the earliest *Severe Sepsis Presentation Time*, this time would be used.

Question 196: **The physician documented severe sepsis not present, and then followed the sepsis protocol. Do I use the time the criteria were met or use the physician's documentation?**

If clinical criteria for severe sepsis had not presented prior to the physician/APN/PA documentation of "Severe Sepsis not present," then this documentation would be disregarded and abstraction of severe sepsis would continue.

If the physician/APN/PA documented "Severe Sepsis not present" within six hours after the *Severe Sepsis Presentation Time* (in this case, defined by the time that the clinical criteria for severe sepsis are met), then value "2" (No) would be selected for *Severe Sepsis Present.*

Question 197: **Why is there a difference between "POA" and "present on admission"? Physicians and coders interpret these terms to mean the same thing and use these terms interchangeably in documentation.**

The documentation of "POA" has varying meanings between facilities and regions. Therefore, it does not always reflect "present on admission" and could mean "present on arrival." Because these phrases typically indicate two very different times, the abstraction guidance does not consider "POA" as synonymous with either.

Question 198: **"On admission" to most providers is when the patient came to the hospital, not when they were admitted to an inpatient room. What is the rationale for using the time when the patient was admitted to an inpatient room over when they came to the hospital?**

With the physician/APN/PA documentation of "Severe Sepsis present on admission," the earliest time the patient arrived to the floor or unit for admission is used as the literal "admission" time. The physician documentation of "present on admission" is abstracted at face value as a specified time for the presentation of severe sepsis. With this specified presentation time, other times (e.g., admission order time) would not be used.

Other Elements

Question 199: **The physician documented "Shock, likely mixed septic plus cardiogenic." Is this acceptable to answer "Yes" to *Septic Shock Present*?**

Yes, this would be acceptable for physician/APN/PA documentation of septic shock.

Question 200: **For determining septic shock, is documentation of "Sepsis, impending septic shock" acceptable to negate septic shock if there are no other criteria or documentation for septic shock?**

Yes, it is acceptable since "impending" is a negative qualifier. If there is no other documentation indicating presence of septic shock, this statement reflects septic shock was not present.

Question 201: **How do you abstract documentation of "Septic unable to be managed at Long Term Acute Care (LTAC), transferred to hospital"?**

Physician/APN/PA or nursing documentation stating "Septic unable to be managed at LTAC, transferred to hospital" would suffice *Severe Sepsis Present* criteria A (infection).

Question 202: **This question was posed to *QualityNet*:**

The patient weighs 192 kg and requires 5,760 mL to meet the 30 cc/kg requirement for septic shock. She received 3,000 mL in the first two hours after time of presentation and then 0.9 NS was started at 150 mL/hr immediately after the completion of the three liters (still within the three-hour window). She was maintained on 0.9 NS at 150 mL/hr for three days. She met the 30 mL/kg required volume approximately 18 hours later. Do I then look for two BPs in the hour following to determine the presence of *Persistent Hypotension*?

This will depend on when severe sepsis presentation time was. The *Septic Shock Present* data element indicates if septic shock presentation is more than six hours after *Severe Sepsis Present*, choose value "2." In this situation, if the time the 30 mL/kg was completely infused is more than six hours after *Severe Sepsis Presentation Time* and *Persistent Hypotension* was present, you would select value "2 "(No) for *Septic Shock Present* anyway.

Here is a follow-up scenario someone on the ListServe posed:

In this case, what if septic shock was present due to an elevated lactate and not waiting for a BP? If your lactate is 4.3, you're giving the fluids no matter what the BP is? So in this case, septic shock is already present. The guidelines state that the time window for vasopressors is the start of *Septic Shock Presentation* through six hours after *Septic Shock Presentation*, demonstrated by *Persistent Hypotension* after *Crystalloid Fluid Administration*. Is this correct?

I am confused. If the fluids are completed at hour 18 and we monitor for persistent or new hypotension within that first hour after fluid administration, we are already outside of the six-hour window to start vasopressors if systolic BP is less than 90. Would the case pass for fluid administration but then fail for vasopressors because the fluids weren't concluded in six hours from septic shock presentation, even though the

fluid guidelines don't mention a time frame?

In this scenario, if *Septic Shock Present* was met by severe sepsis with an *Initial Lactate Level Result* greater than or equal to 4 or documentation of septic shock, *Persistent Hypotension* would be assessed in the hour following the completion of the target ordered volume of crystalloid fluids. Therefore, if the target ordered volume of crystalloid fluids was completed 18 hours later, then *Persistent Hypotension* would be assessed at that time. If *Vasopressor Administration* is required based on the presence of *Persistent Hypotension*, then *Vasopressor Administration* needs to occur within the specified time frame. If a vasopressor was not administered within the specified time frame, then value "2" (No) would be selected for *Vasopressor Administration*.

Other Questions and Comments

Question 203: **Does version 5.5a start with quarter 1 2019 discharges?**

Yes, Specifications manual v5.5a applies to discharges January 1 through June 30, 2019.

Question 204: **Is SEP-1 still being validated? Since 50 percent of the listeners can't agree on an answer to the polling questions, maybe this should be re-examined.**

Yes, the SEP-1 measure is being validated. One of the purposes of the SEP-1 webinar series is to convey measure updates, answer the FAQs, and address areas of confusion for abstractors.

Question 205: **With the reporting of the three-hour and six-hour bundle coming, does CMS plan to update the SEP-1 algorithm or will CMS use the current SEP-1 algorithm to determine these rates?**

There are no plans to update or revise the SEP-1 algorithm, in the specifications manual, for purposes of bundle-level reporting.

Question 206: **Will reporting be the same if you do the one-hour bundle instead of the three- and six-hour bundles? Did the one-hour bundle go away for CMS?**

The SEP-1 measure does not incorporate the "one-hour bundle." The SEP-1

measure has and continues to use the three-hour and six-hour bundle elements.

Question 207: **Will you be providing the correct answers to the polling questions, so we can share them with others when we share the slides?**

The responses to the polling questions are not available alone. A transcript of the presentation, which contains the responses for the polling questions, is available at *QualityReportingCenter.com*.

Question 208: **Please address the fact that there is no consistency between abstractors on many of these data elements, as evidenced by the results of these FAQs, yet this measure is publicly reported. The wide selection of answers to the polling questions, even after your explanations, tells you that there is still a wide gap in understanding and application. My concern is that I feel I am abstracting according to the guidance and my compliance rates aren't always fantastic; yet I see many times on the List Serve that abstractors are not abstracting accurately. This needs to be addressed. It is very frustrating as an abstractor.**

One of the purposes of the SEP-1 webinar series is to convey measure updates, answer FAQs, and address these areas of confusion for abstractors. Future webinars are planned to continue to address areas of confusion and concerns.

Question 209: **Are there any algorithms available for fluids, lactate, antibiotics, etc.?**

The SEP-1 algorithm is available in the Measure Information Form, which provides information regarding all the data elements.

Question 210: **This measure just continues to get harder and harder and it is way too labor intensive for abstractors. Does CMS realize how difficult it is to explain this measure, particularly the *Persistent Hypotension* calculations, to a clinician?**

Thank you for your comments. One of the purposes of the SEP-1 webinar series is to convey measure updates, answer FAQs, and address these areas of concern and confusion for abstractors. The complexity of the measure is understood and CMS, along with the measure stewards and measure writers, continue to focus on ways to decrease abstraction burden.

Question 211: **These are sick patients and the provider does not have the time to write down all that is required for this measure. How can a bedside nurse or physician do this while they are trying to take care of a critical patient?**

Thank you for your comments. The complexity of the measure is understood and CMS, along with the measure stewards and measure writers, continue to focus on ways to decrease provider and abstraction burden.

Question 212: **It would be appreciated if some of these questions were on *QualityNet.* I was researching the PO Vancomycin with C. diff question yesterday and there were no current Q&As on this subject. This might decrease the number of questions being sent in.**

Thank you for your comments. Many of the FAQs presented in this webinar will be added to the searchable questions published on *QualityNet* soon.

Question 213: **Can you please make these webinars longer to address more questions? I understand you will post answers to all questions at a later time but it is helpful to have these answers while the material/questions are still fresh in our minds.**

Thank you for your comments. We are continuing to plan further webinars to address FAQs and areas of confusion.

Question 214: **You are splitting hairs with all this. Was sepsis identified and treated? That's the important part, not all this other stuff in my opinion.**

Thank you for the comments. Each detail of the measure has its importance in improving patient care quality and outcomes. The complexity of the measure is understood and CMS, along with the measure stewards and measure writers, continue to focus on ways to decrease abstraction burden.

Question 215: **How does anyone think the data for the SEP-1 measure is accurate? Even after review of guidelines and examples, abstractors still do not agree on answers as evidenced by your polls.**

Thank you for your comments. One of the purposes of the SEP-1 webinar series is to convey measure updates, answer FAQs, and address these areas of concern and confusion for abstractors. The complexity of the measure is

understood and CMS, along with the measure stewards and measure writers, continue to focus on ways to decrease abstraction burden.