



Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.9 Measure Updates

Presentation Transcript

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Candace Jackson: Hello and thank you for tuning into the *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.9 Measure Updates On Demand* webinar. My name is Candace Jackson, and I am the [Hospital] Inpatient Quality Reporting Program Lead at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be your virtual host for the webinar. I would like to welcome our speakers for this webinar. Noel Albritton is the Lead Solutions Specialist, and Jennifer Witt is the Senior Health Informatics Solutions Coordinator for CMS's Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor.

The purpose of the event is to provide clarification and rationale for the changes and updates to the SEP-1 measure and abstraction guidance in version 5.9 of the specifications manual, to discuss updates to the SEP-1 measure abstraction guidance related to patients with COVID-19, and to provide responses to some of the frequently asked questions.

At the end of the presentation, participants will be able to understand and interpret the updated guidance in version 5.9 of the specifications manual to ensure successful reporting for the SEP-1 measure.

This slide just lists the acronyms that are used throughout the presentation.

If you have questions related to this webinar, you can submit those to the [QualityNet Inpatient Questions and Answers tool](#) at the website on this slide.

That concludes our introduction. I will now turn this over to Noel and Jennifer. Noel and Jennifer, the floor is yours.

Jennifer Witt: Thank you, Candace. Hello everyone and thank you for joining us today. For this presentation, we will be reviewing the updated guidance in specifications manual v5.9.

To begin, updated guidance to manual v5.9 is noted in yellow highlight throughout the manual. We also made changes throughout to align with CMS's plain language guidelines.

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Plain language updates to the abstraction guidance are also in yellow highlight to indicate the change. However, the plain language updates do not change the intent of the abstraction guidance.

The sepsis initial patient population algorithm was updated in manual v5.9 to account for the COVID-19 virus. The algorithm update will exclude cases from the initial patient population if the case has an ICD-10 code for COVID-19. If the case has ICD-10 code of U07.1, the case will not be in the SEP-1 initial patient population. If the case does not have an ICD-10 code of U07.1 but does have physician/APN/PA documentation that COVID-19 is present or suspected, the case will continue through the initial patient population algorithm and potentially be excluded at the *Severe Sepsis Present* data element.

For this presentation, we will be reviewing the updated data elements in the order of the SEP-1 algorithm. The first updates we are going to review are for the *Severe Sepsis Present* data element. Guidance under criteria a in the *Severe Sepsis Present* data element has been updated. The update on this slide states, “Physician/APN/PA, nursing, or pharmacist documentation indicating a patient is receiving an IV or IO antibiotic for an infection and that antibiotic is documented as administered within 6 hours of criteria b and c is acceptable.” In previous versions of the manual, the route of the antibiotic was not specified. As a result, abstractors often submitted questions pertaining to oral antibiotics and this guidance. This update in manual v5.9 specifically includes “IV or IO” antibiotics so that criteria a met by this particular guidance only applies to IV or IO antibiotic documentation.

Further guidance related to infection documentation has also been updated in v5.9. This new guidance states, “If physician/APN/PA documentation within 6 hours following the initial documentation of an infection indicates that the infection is due to a viral, fungal, or parasitic source, do not use the initial documentation of the infection.” We receive quite a few questions pertaining to this topic especially during flu season. The previous guidance simply referred to disregarding documentation of a viral, fungal, or parasitic infection.

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With the new guidance in manual v5.9, if an infection is documented and within 6 hours after the initial documented infection there is documentation the infection is viral, fungal, or parasitic, the initial documented infection could be disregarded. Let's look at a question pertaining to this change.

The question is: Would you use the infection documentation below at 1500 to establish *Severe Sepsis Present* criteria a?

ED APN Note at 1500: "Likely pneumonia."

Hospitalist Note at 1830: "CXR with PNA r/t influenza."

The answer is no, disregard the infection documentation of pneumonia at 1500 because of the physician documentation within 6 hours after 1500 is attributing the pneumonia to a viral infection.

We discussed earlier in the presentation that cases with the ICD-10 code U07.1 are excluded from the sepsis initial patient population. However, the guidance on this slide remains in the *Severe Sepsis Present* data element to account for the cases that have physician/APN/PA documentation that coronavirus or COVID-19 is suspected or present but do not have the ICD-10 code U07.1. Therefore, cases with physician/APN/PA documentation that coronavirus or COVID-19 is suspected or present would still be excluded from the measure even if the ICD-10 code U07.1 is not assigned to the medical record.

Guidance regarding not using hypotensive blood pressure readings obtained during dialysis was also added to the *Severe Sepsis Present* data element. The updated guidance is under criteria c, organ dysfunction, and states, "Do not use hypotensive BPs during a dialysis procedure"

This slide shows new guidance that has been added under criteria c to the INR>1.5 or aPTT>60 sec. This update in v5.9 is based on abstractor feedback regarding a specified time frame to disregard the abnormal criteria.

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The updated guidance states, “If the medical record documentation before an elevated INR or aPTT value shows the patient received an anticoagulant medication in Appendix C Table 5.3, do not use the elevated INR or aPTT level as organ dysfunction. Physician/APN/PA documentation is not required.” If the medical record indicates the patient received an anticoagulant from Table 5.3 before the elevated INR or aPTT value, the elevated INR or aPTT value can be disregarded. If the patient only received an anticoagulant after the elevated INR or aPTT value, you would use the abnormal value to meet criteria c. Let’s review a question regarding this update.

The question is: Would you use the elevated INR value based on the below physician documentation to establish *Severe Sepsis Present* organ dysfunction?

Home Med Rec: Coumadin 2.5 QD

Last dose 2/19/21 at 0800

Lab Report 2/19/21 at 1400

INR this AM 2.5

The answer is no. You would not use the INR of 2.5 to establish organ dysfunction because the documentation demonstrates the patient received an anticoagulant from Table 5.3 before the elevated INR.

The guidance on this slide for the *Severe Sepsis Present* data element was also updated in manual v5.9. This guidance previously stated, “a term that represented or is defined by SIRS criteria or sign of organ dysfunction.” The statement “a term that represents” was removed as this guidance is actually only intended to use a term that is defined by a SIRS criteria or sign of organ dysfunction. The revision to this guidance is based on questions and feedback from abstractors related to deciding what physician/APN/PA documentation will suffice disregarding SIRS criteria or a sign of organ dysfunction.

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The update to v5.9 now states, “Physician/APN/PA documentation of a term that is defined by a SIRS criteria or sign of organ dysfunction is acceptable in place of an abnormal value when the term is documented as normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition that has a non-infectious source/process.” The update here requires a term that defines the abnormal SIRS criterion or sign of organ dysfunction to be documented as normal for the patient, due to a chronic condition, medication, or an acute condition with a non-infectious source to NOT use the abnormal value. If a term is used that does not define the abnormal value that meets SIRS criteria or a sign of organ dysfunction, you would use the abnormal value to meet criteria. Let’s take a look at an example in the following question.

The question is: Would you use the systolic blood pressure value based only on the physician documentation below to establish *Severe Sepsis Present* organ dysfunction?

Vital Signs Flowsheet at 0900: BP 77/49

MD Note at 0945: “patient BP normally runs low”

Yes, you would use the systolic BP of 77 to establish organ dysfunction because the physician documentation does not include a term that defines the abnormal value.

Next, we would like your participation in the following question: “Would you use the elevated heart rate of 125 as SIRS criteria based only on the PA documentation “chronic A-fib, rate controlled?” A, Yes. B, No.

Select “Yes” because the PA documentation does not include a term that defines the elevated heart rate as due to the chronic condition.

Also updated in the *Severe Sepsis Present* data element is the guidance to NOT use SIRS criteria or a sign of organ dysfunction obtained during cardiopulmonary arrest. In manual v5.9, if SIRS criteria or a sign of organ dysfunction was obtained during a code, you would not use the abnormal value to establish severe sepsis.

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This guidance was incorporated into the current guidance that allows SIRS criteria or evidence of organ dysfunction obtained in the operating room (OR), in interventional radiology, during active delivery, during cardiopulmonary arrest (code), or during procedural/conscious sedation.

The guidance in the *Severe Sepsis Present* data element to select Value “1” (Yes) for *Severe Sepsis Present* based on documentation of septic shock was updated in v5.9. The previous guidance referred to selecting Value “1” (Yes) for *Severe Sepsis Present* if clinical criteria for severe sepsis were not documented and there was not physician/APN/PA documentation of severe sepsis, but there was physician/APN/PA documentation of septic shock. The updated guidance in v5.9 states, “Select Value ‘1’ if there is physician/APN/PA documentation of septic shock before or instead of clinical criteria or physician/APN/PA documentation of severe sepsis.” Therefore, if the physician/APN/PA documentation of septic shock was the earliest presentation of severe sepsis and septic shock, you would use the earliest time septic shock was documented to establish *Severe Sepsis Presentation*.

For this question, the question is: Which allowable value would you select for *Severe Sepsis Present* based only on the documentation below?

Severe sepsis clinical criteria met at 1315

MD Note states at 1230: “Septic shock present now, receiving fluids now, monitoring closely.”

You would select Value “1” (Yes) for *Severe Sepsis Present* and use 1230 as the *Severe Sepsis Presentation Time* because septic shock is documented by the physician before severe sepsis clinical criteria were met.

The *Severe Sepsis Presentation Date* and *Time* data elements were also updated with clarifying guidance for scenarios with severe sepsis or septic shock documented multiple times within the same note. The updated guidance under the first bullet point on this slide states, “Of severe sepsis or septic shock is documented multiple times within the same note, use the earliest specified time.”

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This guidance is not new to the *Severe Sepsis Presentation Date and Time* data elements. However, this sub-bullet point was moved under the existing guidance that addresses multiple severe sepsis presentation time.

The guidance that addresses documentation of severe sepsis present on admission was also updated. The new guidance states, “If physician/APN/PA documentation states severe sepsis was present on admission or indicates the patient was admitted with severe sepsis, use the earliest time of the following for the physician/APN/PA documentation of severe sepsis.” The updated guidance now provides direction related to documentation indicating the patient was admitted with severe sepsis. This update was made based on abstractor and hospital feedback regarding physician/APN/PA documentation such as “severe sepsis on admission” or “patient admitted with severe sepsis.” For v5.9, you will use the earliest time based on the available time stamps if there is physician/APN/PA documentation such as “admitted with severe sepsis.” For the next part of the presentation, I’ll turn it over to Noel.

Noel Albritton:

Thanks, Jennifer. The guidance was updated for the *Administrative Contraindication to Care, Severe Sepsis* data element to include the refusal or patient non-compliance is not required to actually result in one of the following not being administered. We frequently see questions about documentation that the patient refused care in general. Often, in this scenario, the patient initially refused care, but there is further documentation that the patient had blood cultures collected, received an IV antibiotic, or received IV fluids. However, due to the patient’s initial refusal of care within the specified time frame for the *Administrative Contraindication to Care, Severe Sepsis* data element, you would select Value “1” (Yes) for the data element even though there is further documentation indicating the refusal did not actually result in blood draws, IV antibiotic, or IV fluids not being administered. Value “1” (Yes) is selected in this scenario because the patient’s initial general refusal can impact the ability to draw blood, administer IV antibiotics, or administer IV fluids within the specified time frames required by other elements of the measure. Let’s take a look at a scenario.

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This question asks: Should you select Value “1” (Yes) or Value “2” (No) for the *Administrative Contraindication to Care, Severe Sepsis* data element based on this scenario?

Severe Sepsis Presentation Date/Time: 1/13/2021 1200

RN documentation at 1/13/2021 1130: “Patient agitated, screaming at staff, and swinging arms”

Physician Notes at 1/13/2021 1230: “Discussed necessity of treatment, patient agreeable to IV antibiotics, blood draw, and IV fluids.”

Select Value “1” (Yes) in this situation. There is nursing documentation stating that the patient is agitated, screaming at staff, and swinging arms within the specified time frame, and this documentation reflects patient noncompliance with care.

The *Administrative Contraindication to Care, Septic Shock* data element was also updated with clarifying guidance regarding documentation of a refusal or patient non-compliance with care. Similar to *Administrative Contraindication to Care, Severe Sepsis* data element updates, the guidance for this data element also states that the refusal or patient non-compliance is not required to actually result in one of the following not being administered. Another example for this scenario could be documentation within the specified time frame that the patient refused all fluids, but the abstractor can see on the MAR that the patient received IV fluids. You would select Value “1” (Yes) for the *Administrative Contraindication to Care, Septic Shock* data element in that scenario because the patient’s initial refusal potentially delayed care which may result in the case failing the measure.

The *Directive for Comfort Care and Palliative Care, Septic Shock* and the *Directive for Comfort Care and Palliative Care, Severe Sepsis* data elements were also slightly updated to state, “Only use physician/APN/PA documentation of an inclusion term documented in the following contexts.”

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In previous manual versions the guidance stated, “Only the earliest physician/APN/PA documentation of an inclusion term documented within the following contexts suffices.” Since physician/APN/PA documentation of an acceptable inclusion term in one of the contexts within the specified time frame for the data element is acceptable, the reference to “the earliest physician/APN/PA documentation” was removed. Abstractors are no longer required to review the medical record for the earliest physician/APN/PA documentation of an inclusion term within an acceptable context. Rather, you would select Value “1” (Yes) if there is physician/APN/PA documentation of an inclusion term within an acceptable context at any point within the specified time frame.

Also, for the *Directive for Comfort Care and Palliative Care, Septic Shock* and the *Directive for Comfort Care and Palliative Care, Severe Sepsis* data elements, new guidance was added to further clarify when documentation of an inclusion term is not acceptable. The new guidance states, “Do not use documentation of an inclusion term if it is not documented in one of the acceptable contexts.” New examples of unacceptable documentation are also included in manual v5.9 that demonstrate unacceptable documentation of an inclusion term such as “Discussion of comfort measures” and “Consider palliative care.” This guidance was added to provide clarity of the abstraction guidance for these data elements and was based on questions submitted by hospitals and abstractors. For these data elements, the documented inclusion term must be documented within one of the acceptable contexts that are found within the data element guidance to select Value “1” (Yes). Let’s review a question related to this scenario.

This question asks: Would you select allowable Value “1” (Yes) or Value “2” (No) for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element based on the documentation below?

MD documentation within time frame: “anticipating patient will be comfort care only, will meet with family.”

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Select Value “2” (No) in this scenario. While the documentation includes “Comfort care” which is an acceptable inclusion term, the inclusion term is not used within one of the acceptable contexts provided in the data element.

For the *Initial Lactate Level Collection* data element, the guidance was updated to clarify abstraction when there are multiple lactates collected before the *Severe Sepsis Presentation Time* and a lactate collected at the same time as the *Severe Sepsis Presentation Time*. The updated guidance states, “If multiple lactate levels are drawn within the specified time frame, use the highest lactate level drawn from the *Severe Sepsis Presentation Time* to 6 hours before. Use a lactate level drawn at the same time as the *Severe Sepsis Presentation Time* if it has the highest level.” In this scenario, if multiple lactates were collected and the highest lactate level was collected at the same time as the *Severe Sepsis Presentation Time*, use the lactate collected at the same time as the *Severe Sepsis Presentation Time* as the initial lactate level collection. This guidance was updated based on questions received from hospitals and abstractors regarding how to abstract the initial lactate level collection when the highest lactate level was collected at the same time as the *Severe Sepsis Presentation Time*.

Further clarification was added to the guidance within the *Initial Hypotension* data element for determining which allowable value to select when the target ordered volume of crystalloid fluids completes before initial hypotension. The updated guidance states, “Select Value “2” if the target ordered volume of crystalloid fluids was completely infused before the hypotensive readings.” This guidance was updated based on questions received from abstractors regarding the correct allowable value to select in this scenario. If you determine that the target ordered volume of crystalloid fluids completed before initial hypotension, select Value “2” (No) for the *Initial Hypotension* data element. The case would proceed in the algorithm to the *Septic Shock Present* data element for abstraction. Next, we would like your participation in the following question.

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Which value would you select for *Initial Hypotension* if 30 mL/kg of normal saline completed at 1500, and the only hypotensive readings included 85/51 at 1530 and 84/53 at 1545? Value “1” (Yes). B. Value “2” (No)

Select Value “2” (No) because 30 mL/kg target ordered volume completed before the hypotensive readings. We often receive questions about which allowable value to select for *Initial Hypotension* when the abstractor cannot determine when the target ordered volume was met. If you cannot determine that the target ordered volume was completely infused before initial hypotension, select Value “1” (Yes) for *Initial Hypotension*. Then, you would determine which allowable value should be selected for the *Crystalloid Fluid Administration* data element.

For the *Crystalloid Fluid Administration* data element, the formatting for the guidance regarding the target ordered volume was updated to clarify when a volume within 10% of the 30 mL/kg volume is acceptable. As you can see, the guidance stating crystalloid fluid volumes ordered that are equivalent to 30 mL/kg is acceptable for the target ordered volume when a crystalloid fluid volume equivalent to 30 mL/kg is not ordered. Only in cases where a volume of 30 mL/kg was not ordered could the target ordered volume be within 10% less than the 30 mL/kg volume. If the patient weighed 74 kg, the 30 mL/kg volume would be 2,220 mL. However, if the physician only ordered 2000 mL, this volume is within 10% of the 30 mL/kg volume. Therefore, the 2000 mL would be the acceptable target ordered volume because this volume of fluids is ordered and it is within 10% less than the 30 mL/kg volume. The guidance was updated as we continue to receive questions from abstractors regarding how to determine the target ordered volume. Next, we would like your participation in the following question.

The patient weighs 90 kg and the physician only ordered 2,500 mL of NS over 2 hours. What is the target ordered volume of crystalloid fluids for this patient? Is it 2700 mL, 2500 mL, 2430 mL, or 2300 mL?

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The correct answer is B, 2500 mL. The physician only ordered 2500 mL of crystalloid fluid. Since 2500 mL is within 10% less than the 30 mL/kg volume, the target ordered volume in this case would be 2500 mL.

The *Crystalloid Fluid Administration Date* and *Time* data elements were updated with further clarifying guidance related to multiple infusions. The updated guidance states, “If multiple infusions end at the same time, and complete the target ordered volume, use the start time of the infusion that was started last.” This guidance was updated based on questions submitted by abstractors. The updated guidance also includes an example of this scenario for further clarification.

The 30 mL/kg volume equals 2500 mL, and there are two orders:

Order 1: NS 2000 mL over 2 hours - started 0800

Order 2: NS 500 mL over 30 minutes - started 0930

Because both infusions end at 1000 based on the ordered duration, you would use 09:30 as the *Crystalloid Fluid Administration Time* because that was the start time of the infusion that was started last.

Based on feedback and questions from abstractors, the *Septic Shock Presentation Date* and *Time* data elements were updated to clarify the presentation date and time to abstract when septic shock is met by severe sepsis with persistent hypotension. The guidance states, “For persistent hypotension, use the time of the last consecutive blood pressure reading that identifies the presence of persistent hypotension.” The updated guidance for manual v5.9 states, “If persistent hypotension was identified by either of the following, use the time of the latest hypotensive reading in the hour for the time of persistent hypotension.” Two or more blood pressures were documented within the time frame and persistent hypotension is unable to be determined and a vasopressor was administered. Only one blood pressure was documented within the time frame that was hypotensive and a vasopressor was administered.

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These updates provide clarity for establishing the *Septic Shock Presentation Date* and *Time* based on the specific scenario of how persistent hypotension is determined. Next, we will review a question related to this scenario.

This question asks: Which date and time would you use for the *Septic Shock Presentation Date* and *Time* based only on the documentation below?

Severe sepsis presentation time: 1200

Hour to assess for Persistent Hypotension: 1300 to 1400

BP 93/56 at 1330

BP 85/53 at 1350

MAR: vasopressor administered 1420

Use 1350 as the *Septic Shock Presentation Time* because 1350 is the time of the latest hypotensive reading in the hour. The time of the hypotensive blood pressure reading is used because hypotension that persist is the criterion for establishing the presence of septic shock. The time of the vasopressor administration is not used to determine the *Septic Shock Presentation Time*.

The *Septic Shock Presentation Date* and *Time* data elements were also updated with clarifying guidance for scenarios with septic shock documented multiple times within the same note. The updated guidance under the first bullet point on this slide states, “If septic shock is documented multiple times within the same note, use the earliest specified time.” This guidance is not new to the *Septic Shock Presentation Date* and *Time* data elements. However, the previous location of this guidance within the data elements was not ideal. So, this bullet point was moved within the data element to a location near other guidance related to establishing the *Septic Shock Presentation Date* and *Time* when septic shock is documented multiple times.

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The guidance for documentation that states septic shock was present on admission was also updated. The new guidance states, “If physician/APN/PA documentation states septic shock was present on admission or indicates the patient was admitted with septic shock, use the earliest time of the following for the physician/APN/PA documentation of septic shock.” The updated guidance now provides direction related to documentation indicating the patient was admitted with septic shock. This update was made based on abstractor and hospital question regarding physician/APN/PA documentation such as “septic shock on admission” or “patient admitted with septic shock.” Next, we will review a scenario related to this guidance.

This question asks: Which date and time would you use for the *Septic Shock Presentation Date* and *Time* based only on the documentation below?

PA Note: “septic shock on admission.”

PA Note date/time: 3/4/2021 1600

Admit Order date/time: 3/3/2021 2220

Arrival time to unit: 3/3/2021 2345

Use the date/time of the admit order, which is 3/3/2021 at 2220, because the PA documentation indicates the patient was admitted with septic shock and the admit order date/time is the earliest.

The first bullet point on this slide was updated with clarifying guidance for the *Persistent Hypotension* data element. In previous versions of the manual, this guidance stated, “If there are more than two blood pressures documented, refer to the last two consecutive blood pressures within the hour.” Based on abstractor feedback regarding scenarios that only include two blood pressures documented within the hour, this guidance was updated in v5.9. The guidance now states, “If two or more blood pressures are documented, refer to the last two consecutive blood pressures within the hour.”

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Then, to determine the correct value to abstract when two or blood pressures are documented within the hour to assess for *Persistent Hypotension*, you would use the sub-bullet points provided on this slide. Let's review a question pertaining to this scenario.

This question asks: Which allowable value would you select for *Persistent Hypotension*?

The hour to assess for *Persistent Hypotension* is from 0950 to 1050.

Blood Pressure readings at 1020 of an SBP of 92 and at 1045 and SBP of 84

Select Value "2" (No) because there is a normal blood pressure followed by a low blood pressure. In previous versions of the manual, Value "3" would be selected if there was a normal blood pressure followed by a hypotensive blood pressure. The guidance was updated in manual v5.8 to allow Value "2" to be selected and prevent cases from failing based on documentation of a normal blood pressure followed by a hypotensive blood pressure.

Further updates were made to the *Persistent Hypotension* data element guidance related to selecting Value "1" when *Persistent Hypotension* is unable to be determined but a vasopressor was administered. The updated guidance states, "Select Value '1' if two or more blood pressures were documented within the time frame and *Persistent Hypotension* is unable to be determined, and a vasopressor was administered." The update also includes a new example of a scenario in which this guidance applies. The example states:

One-hour time frame: 0800 to 0900

Blood pressures documented at 0830 of 95/60 and at 0845 of 86/54

MAR: Vasopressin started at 0930

Select Value "1" for *Persistent Hypotension*. We are also often asked about the time frame for administration of the vasopressor to suffice this guidance. Select Value "1" for the *Persistent Hypotension* data element.

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The guidance in the *Persistent Hypotension* data element does not provide a specified time frame for the administration of a vasopressor. Therefore, you are only reviewing to determine if *Persistent Hypotension* was unable to be determined and if a vasopressor was administered. If Value “1” is selected for *Persistent Hypotension*, the case will proceed to the *Vasopressor Administration* data element where the vasopressor timing will be reviewed. Further guidance was added to the *Persistent Hypotension* data element to address scenarios when only one blood pressure was documented within the hour. The guidance states, “Select Value ‘1’ if only one blood pressure was documented within the time frame that was low and a vasopressor was administered.” An example is also included in the updated guidance for this scenario. It states:

One-hour time frame: 1300 to 1400

Only blood pressure documented at 1425 was 87/53

MAR: Levophed started at 1500

Select Value “1” for *Persistent Hypotension*. Next, let’s review another scenario.

This question asks: Which allowable value would you select for *Persistent Hypotension*?

Hour to assess for Persistent Hypotension is from 0950 to 1050

BP readings at 1020 is SBP = 92 and 1045 SBP = 84

MAR: Levophed IV start time: 1130

Select Value “1” (Yes) because there are two or more blood pressures documented within the hour, and *Persistent Hypotension* is not able to be determined. However, a vasopressor was administered. The scenario in this question is similar to the previous scenario we reviewed. However, there is a slight difference. The earlier question contained a normal blood pressure reading followed by a hypotensive reading, and Value “2” (No) was selected for the *Persistent Hypotension* data element in that scenario.

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In the scenario on this slide, there is a normal blood pressure followed by a hypotensive blood pressure, but a vasopressor was administered. In this scenario, you would select Value “1” (Yes) for the *Persistent Hypotension* data element.

Guidance within the *Initial Hypotension*, *Persistent Hypotension*, and *Septic Shock Present* data elements was updated to clarify scenarios where the hypotensive readings would not be used to meet criteria. This update is based on frequently asked questions received from abstractors related to hypotensive readings documented during a code and during dialysis. The updated guidance states, “Do not use hypotensive BPs obtained in the operating room (OR), in interventional radiology, during active delivery, during cardiopulmonary arrest (code), or during procedural/conscious sedation. Do not use hypotensive BPs documented during a dialysis procedure.” In manual v5.9, if hypotensive readings are documented during a code, disregard those readings. Also, if the patient was hypotensive during a dialysis procedure, you would disregard those hypotensive readings. It’s important to understand that based on this updated guidance, only hypotensive readings obtained during a code or during dialysis would be disregarded. If the patient was hypotensive, for example, prior to dialysis or after completing dialysis, you would use those hypotensive readings. Let’s review a scenario pertaining to this guidance.

This question asks: Would you use the hypotensive blood pressure readings below to meet criteria?

Code Sheet – Code start time 1610, Code stop time 1628

Code Vital Signs:

1611: BP = 63/48

1620: BP = 65/47

1630: BP = 75/54

1640: BP = 84/57

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You would not use the hypotensive readings at 1611 and 1620 because these hypotensive readings were obtained during the code. You would use the hypotensive readings at 1630 and 1640 because these readings were obtained after the code. It's important to recognize in this scenario that the medical record documentation states when the code started and ended. The documentation demonstrates the code was in process between 1610 to 1628. If your medical record documentation does not provide the time when the code was in process, you would not be able to determine if hypotensive readings were obtained during the code. If you are unable to determine when the code occurred, you would use the hypotensive readings to meet criteria. Let's review another question related to this updated guidance.

This question asks: Would you use the hypotensive blood pressure readings below to meet criteria?

Notes – Dialysis start time 0700, Dialysis end time 0900

Vital Signs Flowsheet:

0620: BP = 82/58

0645: BP = 87/56

0715: BP = 85/61

0800: BP = 81/54

You would use the hypotensive readings at 0620 and 0645 because these readings were obtained before the start of the dialysis procedure. You would not use the hypotensive readings at 0715 and 0800 because these readings were obtained during the dialysis procedure.

Also, for the *Initial Hypotension*, *Persistent Hypotension*, and *Septic Shock Present* data elements, the guidance related to documentation of a term that is defined by a systolic blood pressure <90 or a MAP <65 was updated.

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In previous versions, this guidance referred to “a term that represents” or is defined by a systolic blood pressure <90 or a MAP <65. The previous guidance that included “a term that represents” was removed as this guidance is intended only to use terms that are defined by a systolic blood pressure <90 or a MAP <65 such as the term “hypotension.” The inclusion of “represents” in this guidance resulted in terms that do not actually define an abnormal value being used to disregard an abnormal value. Based on the updated guidance in v5.9, if the physician documented “patient states low blood pressure is normal,” you would continue to use any hypotensive readings because this physician documentation does not include a term that defines a systolic blood pressure <90 or a MAP <65 such as the term “hypotension.”

These two bullet points received updates in the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. The first bullet point on this slide states, “Physician/APN/PA documentation attesting to performing or completing a physical examination, perfusion assessment, sepsis focused exam, or systems review.” You may recall in previous versions of the manual this guidance stated, “Physician/APN/PA documentation indicating or attesting to performing or completing a physical examination.” The inclusion of “indicating” was removed because this guidance is intended to allow for physician/APN/PA documentation attesting to performing an exam. The inclusion of “indicating” within the previous guidance caused abstractors to submit questions related to what physician/APN/PA documentation would be acceptable to meet this guidance. The second bullet point on this slide states, “Physician/APN/PA documentation indicating they performed or completed a review of at least five of the following eight parameters. Reference to the parameters must be made in physician/APN/PA documentation. Physician/APN/PA documentation does not need to reference all parameters within the same note.” You may recall, this bullet point used to include “physician/APN/PA documentation indicating or attesting to performing or completing a review.” However, the intention of this bullet point is to allow for physician/APN/PA documentation demonstrating they performed or completed five of the eight parameters.

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Therefore, the update to this guidance in manual v5.9 removed “attesting” from this bullet point. Thank you for participating in our review of the SEP-1 measure updates in specifications manual v5.9. Candace, I will turn it back over to you.

Candace Jackson: Thank you, Noel and Jennifer. Again, if you have questions that are pertinent to the webinar topic, please submit them to the [QualityNet Inpatient Questions and Answers tool](#).

This event has been approved for one CEU. CEU credit can be obtained by clicking on the link on this slide.

Thank you for watching our On Demand webinar. We hope you have a great day.