



Hospital Inpatient Quality Reporting (IQR) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR)

Outreach and Education Support Contractor

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

Presentation Transcript

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April 13, 2021
12:30 p.m. ET

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Candace Jackson: Hello and thank you for tuning in to the *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.9 Measure Questions and Answers* 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 host for today's webinar. Before we begin, I would like to make a few announcements. This program is being recorded and a transcript of the presentation will be posted to the inpatient website, www.QualityReportingCenter.com, in the upcoming weeks.

If you are registered for this event, the links to the slides were sent out a few hours ago. If you did not receive that email, you can download the slides at www.QualityReportingCenter.com. This webinar has been approved for one continuing education credit. If you would like to complete the survey for today's events, please stand by after the event. We will display a link for the survey that you would need to complete for continuing credit. The survey will no longer be available if you leave the event early. If you do need to leave prior to the conclusion to the event, a link of the survey will be available in the summary email one to two business days after the event. Unfortunately, we will not be able to have a live Q&A session at the end of the webinar today. If you have questions related to this webinar, you can submit those questions to the [QualityNet Inpatient Question and Answer Tool](#) which will be discussed later in this presentation. 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 this event is to clarify frequently asked questions related to the SEP-1 measure and guidance in version 5.9 of the specifications manual and to discuss updates to the SEP-1 measure for patients with COVID-19.

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.

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

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 and thank you for joining us today. In this presentation, we will review questions and answers followed by the guidance related to each scenario. We have also included several questions we would like your participation in answering.

To begin, let's review several different scenarios regarding the *Severe Sepsis Present* data element. Our first question asks: "There is physician documentation that states, "patient positive for COVID-19." However, this medical record does not include ICD-10-CM code U07.1. Which allowable value will be selected for *Severe Sepsis Present*?"

Noel Albritton:

Select Value 2 (No) because there is physician, APN, or PA documentation that COVID-19 is present.

The sepsis initial patient population algorithm was updated in manual version 5.9 to account for the COVID-19 virus. The algorithm update will exclude cases from the initial patient population if the case has ICD-10 code U07.1 for COVID-19. If the case has the ICD-10 code U07.1, the case will not be included in the SEP-1 initial patient population. If the case does not have ICD-10 code U07.1, the case will continue through the initial patient population algorithm.

The guidance on this slide remains in the *Severe Sepsis Present* data element to account for 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 present or suspected to be present would still be excluded from the measure even if the ICD-10 code U07.1 is not assigned to the medical record.

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Jennifer Witt: This question asks: Would you use the inspection documentation at 0800 below to establish *Severe Sepsis Present* criteria A? The ED APN note at 0800 states possible pneumonia. The hospitalist's note at 0930 has pneumonia related to influenza.

Noel Albritton: No. Disregard the documentation of pneumonia at 0800 because the physician documentation within six hours after 0800 attributes pneumonia to a viral infection.

This guidance states if physician/APN/PA documentation within six hours following the initial documentation of an infection indicates the infection is due to a viral, fungal, or parasitic source, do not use the initial documentation of the infection. The updated guidance in version 5.9 instructs you to disregard documentation of the initial infection if that infection was documented as due to a viral, fungal, or parasitic infection within six hours after the infection was documented. Let's review another scenario related to the *Severe Sepsis Present* data element.

Jennifer Witt: This *Severe Sepsis Present* question asks: Would you use the elevated INR value based on the below physician documentation to establish *Severe Sepsis Present* organ dysfunction? The lab report on 1/12/2021 at 1500 has an INR of 2.5. The MAR states coumadin 2.5 every day, last dose on 1/13/2021 at 0700.

Noel Albritton: Yes. Use the INR of 2.5 to establish organ dysfunction because the documentation reflects that the patient received an anticoagulant from Table 5.3 after the elevated INR.

This guidance states if the medical record documentation before an elevated INR or aPTT value shows the patient received an anti-coagulant medication from Appendix C Table 5.3, do not use the elevated INR or aPTT level as organ dysfunction. Physician/APN/PA documentation is not required. The guidance refers to documentation in the medical record demonstrating the patient received an anticoagulant from Table 5.3 before an elevated INR or aPTT value.

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If the patient only received an anticoagulant after the elevated INR or aPTT, you would use the abnormal value to meet criteria C organ dysfunction

Jennifer Witt: This question asks: Would you use the abnormal platelet value to establish *Severe Sepsis Present* organ dysfunction based only on the physician documentation below? The lab report at 0600 has a platelet of 87. The APN note at 0845 states platelets run low for patient.

Noel Albritton: Yes. Use the platelet value of 87 to establish organ dysfunction. Because the APN documentation does not include a term that defines the abnormal value. Let's review another *Severe Sepsis Present* scenario.

Jennifer Witt: This scenario is like the previous scenario with a slight difference. This question asks: Would you use the abnormal platelet value to establish *Severe Sepsis Present* organ dysfunction based only on the physician documentation below? The lab report at 0600 has platelets at 87. The APN note at 0845 states cytopenia normal for patients.

Noel Albritton; No. Do not use the platelet value of 87 to establish organ dysfunction because the APN documentation includes the term thrombocytopenia which defines the abnormal value and indicates the abnormal value is normal for the patient.

The guidance on this slide for *Severe Sepsis Present* data element states 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, the guidance here requires a term that defines the abnormal search criterion or sign of organ dysfunction to be documented as normal for the patient due to a chronic condition, a 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, you would use the abnormal value to meet criteria.

Next, we would like your participation in the following question.

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- Jennifer Witt:** Would you use the white blood cell count of 3.5 as SIRS criteria based only on the MD documentation of low WBC's likely related to recent chemo?
- Noel Albritton:** The answer is Yes. Use the white blood cell value of 3.5 because the MD documentation does not include the abnormal value or a term that defines the white blood cell value of 3.5 as being due to the medication.
- Jennifer Witt:** Continuing with our *Severe Sepsis Present* scenarios, this question asks: Would you use the hypotensive blood pressure reading below to establish *Severe Sepsis Present* organ dysfunction? The code sheet has that the code start time is 1315; the code stop time is 1325; the code vital signs is 1315. There's a blood pressure of 51 over 34. At 1320, there's a blood pressure of 55 over 37. At 1325, there's a blood pressure of 72 over 51. At 1330, there's a blood pressure of 83 over 52.
- Noel Albritton:** Do not use the hypotensive readings at 1315, 1320, and 1325 because these readings were obtained during the code. You would use the reading at 1330 because this reading was not obtained during the code.
- Based on the guidance on this slide, if SIRS criteria or sign of organ dysfunction was obtained during a code, do not use the abnormal value to establish severe sepsis. However, you would continue to use the SIRS criteria or sign of organized function obtained before or after a code.
- Jennifer Witt:** This *Severe Sepsis Present* question asks: Which allowable value would you select for *Severe Sepsis Present* based only on the documentation below? The PA note at 1630 states septic shock present, fluid running, monitor closely. Severe sepsis clinical criteria were met at 1715.
- Noel Albritton:** Select Value 1 (Yes) for *Severe Sepsis Present* and use 1630 as the *Severe Sepsis Presentation Time* because the septic shock is documented by the PA before severe sepsis clinical criteria were met.
- This guidance states to 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.

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Based on the physician documentation of septic shock being the earliest presentation of severe sepsis and septic shock you would use the earliest time septic shock was documented to establish *Severe Sepsis Presentation*.

Jennifer Witt:

Next, let's review a scenario related to the *Severe Sepsis Presentation Date & Time* data elements. The question asks: Which date and time would you use for the *Severe Sepsis Presentation Date* and *Time* based only on the documentation below? The MD note states severe sepsis on admit. The arrival time to the unit was 4/1/2021 at 0345. The MD note date and time for the admin order date and time is 4/1/2021 at 0230, and the ED disposition to admit was 4/1/2021 at 0235.

Noel Albritton:

Use the date and time of the admit order 4/1/2021 at 0230 because the MD documentation indicates the patient was admitted with severe sepsis and the admin order was the earliest date and time of the available time stamps in the guidance.

This guidance states if physician/APN/PA documentation state 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. Based on our scenario in the last question, the physician documentation "severe sepsis on admit" indicates the patient was admitted with severe sepsis. Therefore, we would use the earliest date and time of the available time stamps listed in the guidance to determine the *Severe Sepsis Presentation Date* and *Time*.

Jennifer Witt:

Next, let's review a scenario related to the *Administrative Contraindication to Care* data element. 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 and time are 3/4/2021 at 1400. RN documentation on 3/4/2021 at 1430 states patient agitated and states he does not like hospitals.

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Noel Albritton: Select Value 2 (No) because the nursing documentation does not reflect patient refusal or non-compliance with care that could result in not being able to administer blood draws, IV antibiotics, or IV fluids.

This guidance for the *Administrative Contraindication to Care, Severe Sepsis* data element allows for more general documentation of a refusal or documentation of patient non-compliance with care, such as pulling out IVs that could result in not being able to administer blood draws, IV antibiotics, or IV fluids. However, Value 2 (No) was selected in the scenario on our previous slide because the documentation did not include a general refusal or documentation of patient non-compliance that could result in the inability to draw blood, administer IV antibiotics, or administer IV fluids.

Jennifer Witt: Next, let's review a scenario related to the *Directive for Comfort Care and Palliative Care, Severe Sepsis* data element. This question asks: Should Value 1 (Yes) be selected for the *Directive for Comfort Care and Palliative Care, Severe Sepsis* data element if the physician documented poor prognosis, plan to discuss hospice care with families within the specified time frame?

Noel Albritton: No. Select Value 2 (No) based on this documentation. While the inclusion term "hospice" is included in the physician documentation, the inclusion term is not documented within an acceptable context.

This guidance states do not use documentation of an inclusion term if it is not documented in one of the acceptable contexts. Since the physician documentation plan to discuss hospice care with family refers to discussing hospice with the family, rather than planning or ordering hospice, you would select Value 2 (No) based on this documentation.

Jennifer Witt: Next, let's review a couple scenarios related to the *Initial Lactate Level Collection* data element. This question asks: Which lactate collection would you select for the *Initial Lactate Level Collection? Severe Sepsis Presentation Time* is at 1200.

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There is a lactate draw time at 1020, with a result of 3.5; a lactate draw time at 1200, with a result of 3.0; and a lactate draw time at 1420, with a result of 4.0.

Noel Albritton: Use the lactate drawn at 1020 with the result of 3.5 as the *Initial Lactate Level Collection* because this is the highest lactate level collected within the six hours before the *Severe Sepsis Presentation Time*. Let's review another *Initial Lactate Level Collection* scenario.

Jennifer Witt: This question asks: Which lactate collection would you select for the *Initial Lactate Level Collection*? *Severe Sepsis Presentation Time* is at 1200. A lactate draw time is at 1020, with a result of 3.0; a lactate draw time of 1200, with the results of 4.0; and a lactate draw time at 1420, with the results of 4.5.

Noel Albritton: Use the lactate drawn at 1200 with the result of 4.0 as the *Initial Lactate Level Collection* because this draw time is the same as the *Severe Sepsis Presentation Time* and it is the highest lactate level within the six hours before the *Severe Sepsis Presentation Time*.

This guidance states if multiple lactate levels are drawn within the specified time frame, use the highest lactate level drawn from *Severe Sepsis Presentation Time* to six hours before. Use a lactate level drawn at the same time as the *Severe Sepsis Presentation Time* if it has the highest level. In the scenario on the previous slide, multiple lactates were collected. The lactate drawn at 1200 was collected at the same time as the *Severe Sepsis Presentation Time*, and this lactate collection has the highest result of the lactates collected within the six hours before the *Severe Sepsis Presentation Time*. Next, we would like your participation in answering the following question.

Jennifer Witt: Which lactate collection would you select for the *Severe Sepsis Presentation Time* if the *Severe Sepsis Presentation Time* was 1800? A: Lactate draw time of 1600, with a result of 2.2. B: Lactate draw time at 1800, with a result of 2.9. C: Lactate draw time at 1900, with a result of 3.3.

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Noel Albritton: Select B: Lactate draw time at 1800, with a result of 2.9, because this lactate was drawn at the same time as the *Severe Sepsis Presentation Time* and it has the highest result. If there were multiple lactate levels only drawn in the three hours after the *Severe Sepsis Presentation Time*, then we would use the lactate drawn with the highest level that was drawn within the three hours after severe sepsis.

Jennifer Witt: Next, let's review several scenarios related to the *Initial Hypotension* data element. This question asks: Which allowable value would you select for *Initial Hypotension* based on the scenario below? Patient weighs 60 kilograms, 30 mil per kilogram requires 1800 milliliters of crystalloid fluids. The EMS record states 1000 milliliters normal saline started at 1500. No rate, duration, or end time documented by EMS. ED MAR as 1000 milliliters normal saline over one hour started at 1615. The ED vital sign flow sheet has a blood pressure of 80 over 52 at 1645 and a blood pressure of 87 over 54 at 1700.

Noel Albritton: Select Value 1 (Yes) for *Initial Hypotension* because the target order volume of crystalloid fluids is not documented as completely infused before the hypotensive blood pressure readings.

This guidance states select Value 2 if the target ordered volume of crystalloid fluids was completely infused before the hypotensive readings. If you determine that the target ordered volume of crystalloid fluids completed before initial hypotension, select Value 2 (No) for *Initial Hypotension*. However, if you cannot determine that the target ordered volume of crystalloid fluids was completely infused before the hypotensive readings, you would select Value 1 (Yes) for *Initial Hypotension*. In the scenario on the previous slide, the fluids administered by EMS did not have a rate, duration, or end time documented. Therefore, you cannot determine that the target ordered volume of crystalloid fluid is completed before *Initial Hypotension*. Let's review another initial hypertension scenario.

Jennifer Witt: This question asks: Would you use the hypotensive reading to establish *Initial Hypotension* based on the below documentation?

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Dialysis start time is at 1530, end time at 17 30. The vital sign slow sheet at 1800 has a blood pressure of 84 over 61.

Noel Albritton: Yes, use the hypotensive reading at 1800 as one of the readings to establish *Initial Hypotension* because the documentation demonstrates the hypotensive reading was not obtained during the dialysis procedure.

Based on this guidance, do not use hypotensive blood pressure readings obtained during dialysis. However, you would use hypotensive readings obtained before or after a dialysis procedure. To determine if a hypotensive reading was obtained during the dialysis procedure, the medical record documentation must clearly indicate when the patient was in the dialysis procedure. Often patient vital signs are taken before or after dialysis, and you would use hypotensive blood pressure readings obtained before or after dialysis. You would only not use hypotensive readings obtained during the dialysis procedure.

Jennifer Witt: Which allowable value would you select for *Initial Hypotension* based on the scenario below? EMS record at 0900 has a blood pressure of 77 over 50. At 0915, there's a blood pressure of 81 over 55. The ED arrival time is at 0932. The ED vital sign slow sheet at 0935 has a blood pressure of 92 over 59. At 0945, a blood pressure was 84 over 58. At 0955, a blood pressure was 82 over 50.

Noel Albritton: Select Value 2 (No) for *Initial Hypotension* because the criteria to meet *Initial Hypotension* were met prior to arrival and the first blood pressure on arrival was not hypotensive.

This guidance states to determine the presence of Initial Hypotension you may use documentation and pre-hospital records that are considered part of the medical record. Select Value 2 if the criteria for determining initial hypotension were met prior to arrival and the patient is not hypotensive on arrival to the ED or hospital. In the scenario on the previous slide, *Initial Hypotension* was met by the hypotensive readings documented by EMS. However, the blood pressure on arrival to the ED was not hypotensive, so Value 2 (No) was selected for *Initial Hypotension*.

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We often receive questions related to looking further in the medical record at blood pressures documented after arrival to the ED or hospital. If the criteria for *Initial Hypotension* was met prior to arrival, and the first blood pressure on arrival to the ED or hospital was normal, you would not continue reviewing further blood pressures after arrival to the ED or hospital. Upon selecting Value 2 (No) for *Initial Hypotension*, the case will proceed to the *Septic Shock Present* data element for abstraction.

Jennifer Witt: Next, let's review a few scenarios regarding the *Crystalloid Fluid Administration* data element. This question asks: Is the target ordered volume in this scenario 1890 milliliters, 2100 milliliters, or 3000 milliliters. The patient weighs 70 kilograms, and the PA orders normal saline 3000 milliliters bolus at 1000 milliliters an hour.

Noel Albritton: The target ordered volume is 2100 milliliters based on the patient's weight and the ordered volume.

This guidance states crystalloid fluid volumes ordered that are equivalent to 30 milliliters per kilogram are the target ordered volume. Only in cases where 30 milliliters per kilogram were not ordered would the target ordered volume be within 10 percent less than 30 milliliters per kilogram. More than 30 milliliters per kilogram was ordered. The target ordered volume would continue to be 30 milliliters per kilogram. In the scenario on the previous slide, 1890 milliliters is not used because the 30 milliliters per kilogram volume was ordered and 3000 milliliters is not used as a target ordered volume because the patient's weight is 70 kilograms, which would make the target order volume 2100 milliliters.

Jennifer Witt: This *Crystalloid Fluid Administration* question asks: Which weight would you use to determine the target ordered volume based only on the documentation below? The MD ordered a LR IV 2550 milliliters over two hours, volume based on weight of 85 kilograms. Order comments, "Use IBW if patient's BMI is greater than 30."

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Noel Albritton: Use the weight of 85 kilograms that is included in the fluid order because this weight has the highest priority. Do not use the ideal body weight to determine the target ordered volume because the MD documentation does not meet the documentation requirements. Let's review another *Crystalloid Fluid Administration* scenario.

Jennifer Witt: This question asks: Which weight would you use to determine the target ordered volume based only on the documentation below? At 1300, there's an actual body weight of 75 kilograms. At 1400, the MD orders normal saline IV, 1500 milliliters at 1000 milliliters an hour based on IBW of 50 kilograms.

Noel Albritton: Use the actual body weight of 75 kilograms because the MD documentation in the order does not meet the conditions required to use the ideal body weight to determine the target ordered volume.

This guidance states physician/APN/PA can use ideal body weight to determine the target ordered volume if all of the following conditions are met. Other acceptable weight terms include "predicted weight," "dosing weight," and "adjusted body weight." The conditions that must be met are physician/APN/PA documents the patient is obese or has a BMI greater than 30. Physician/APN/PA documents ideal body weight is being used to determine the target ordered volume, and ideal body weight is present in the medical record, and the abstractor should not calculate the ideal body weight. We often receive questions based on the inclusion of a general statement such as an order comment that states, "Use IBW if patient BMI is greater than 30." This comment does not meet the conditions noted in the guidance on this slide to use the ideal body weight to determine the target ordered volume. The physician/APN/PA documentation must meet the documentation requirements provided in this guidance to use the ideal body weight to determine the target ordered volume. We also receive questions based on the ideal body weight being included in the physician's fluid order.

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Even though the ideal body weight is in the fluid order, the condition provided in the guidance to use the ideal body weight must be met. The ideal body weight included in the fluid order alone would not suffice to use the ideal body weight to determine the target ordered volume of crystalloid fluids. Next, we'd like your participation in answering the following question.

Jennifer Witt: Which volume would you use to determine the target ordered volume based on the APN documentation of patient BMI 35, bolus based on IBW, and the RN documentation on flow sheet "IBW 70 kilograms"? A: 1900 milliliters; B: 2000 milliliters; C: 2100 milliliters; or D: 2200 milliliters.

Noel Albritton: Select C and use 2100 milliliters as the target ordered volume. The APN documentation meets the conditions to use ideal body weight, and the ideal body weight appears in the RN documentation. The guidance requires the physician/APN/PA documentation that the patient is obese or has a BMI greater than 30, and the physician/APN/PA documents that the ideal body weight is being used to determine the target ordered volume. The actual ideal body weight value is not required to be documented by the physician/APN/PA. Therefore, the APN and nursing documentation in the scenario on this slide are acceptable to use the ideal body weight to determine the target ordered volume.

Jennifer Witt: Next, let's review a scenario related to the *Septic Shock Present* date element. This question asks: Would you use the hypotensive blood pressure readings below to establish *Septic Shock Present*? The OR start time is 0630 and the OR in time is 0730. The OR flow sheet at 0655 has a blood pressure of 85 over 57. The OR flow sheet at 0715 has a blood pressure of 83 over 55. The PACU flowsheet at 0740 has a blood pressure of 82 over 52, and the PACU flowsheet at 0750 has a blood pressure of 86 over 54.

Noel Albritton: Do not use the hypotensive reading that 0655 and 0715 because these readings were obtained in the OR. You use the hypotensive readings at 0740 and 0750 because these readings were not obtained in the OR.

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This guidance states do not use hypotensive blood pressures obtained in the operating room, in interventional radiology, during active delivery, or during cardiopulmonary arrest or code, or during procedural or conscious sedation. In our example on the previous slide, the medical record clearly recorded the time frame the patient was in the OR, and there are two hypertensive readings documented while the patient was in the OR.

Those hypotensive readings would not be used; however, the guidance does not disregard hypotensive readings obtained while the patient is in the PACU. Therefore, we would use the hypotensive readings documented outside of the OR to establish septic shock.

Jennifer Witt: Next, let's review a couple scenarios related to the *Septic Shock Presentation Time* data element. This question asks: Which time would you use for the *Septic Shock Presentation Time* based only on the documentation below? Severe sepsis of presentation time is at 0600. The hour to assess for *Persistent Hypotension* is 0700 to 0800. There's a blood pressure of 85 over 53 at 0750. On the MAR, the vasopressor was administered at 0630.

Noel Albritton: Use 0750 as the *Septic Shock Presentation Time* because 0750 is the time of the hypotensive reading in the hour to assess for persistent hypotension.

Based on this guidance, if there is only one blood pressure documented within the time frame, and it is a hypotensive reading, and the vasopressor was administered, use the time of the latest hypotensive reading in the hour for the time of persistent hypotension. In the scenario on the previous slide, we use 0750 as the presentation time because that was the time of the only blood pressure reading documented within the hour to assess for persistent hypotension and the vasopressor was administered. We would not use the time of the vasopressor administration as the *Septic Shock Presentation Time*. Let's review another scenario.

Jennifer Witt: Also related to the *Septic Shock Presentation Time* data element, this question asks: Which time would you use for the *Septic Shock Presentation Time* based only on the documentation below?

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Severe sepsis presentation time was at 0600. Initial lactate level at 0645 had the results of 4.5. The MD critical care note was opened at 0530. There's untimed documentation of septic shock, and the assessment specified time at 0630 has septic shock.

Noel Albritton: Use 0630 as the *Septic Shock Presentation Time* because multiple presentation times are available and 0630 is the earliest specified time of septic shock presentation.

This guidance states for patients with multiple septic shock presentation times to only abstract the earliest presentation time. If septic shock is documented multiple times within the same note, use the earliest specified time. In the previous scenario, septic shock was met by physician documentation of septic shock and clinical criteria. There was a note that contained documentation of septic shock multiple times both with and without a specified time. Based on the guidance on this slide, you would use 0630 because it is the earliest septic shock presentation time and it was the earliest specified time within the note that contained septic shock documented multiple times.

Jennifer Witt: This scenario is related to the *Septic Shock Presentation Date and Time* data elements. 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 was 4/22/2021 at 1500. The initial lactate level results of five were on 4/22/2021 at 1530. The MD notes admitted with septic shock. The MD note date and time were 4/23/2021 at 0800. There's an admit order with the date and time of 4/22/2021 at 1630, and the arrival time to unit was 4/22/2021 at 1500.

Noel Albritton: Use the arrival date and time to the unit on 4/22/2021 at 1500 because the MD documentation indicates the patient was admitted with septic shock and the arrival time to the unit is the earliest time of the available time stamps for the guidance.

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This 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. In our previous scenario, septic shock was met by clinical criteria and physician documentation that the patient was admitted with septic shock.

Even though clinical criteria were met, the time documented for the patient's arrival to the unit was used as a septic shock presentation time because it was the earliest septic shock presentation time available.

Jennifer Witt: Next, let's review several different scenarios regarding *Persistent Hypotension*. This question asks: Which allowable value you would select for *Persistent Hypotension*? The hour to assess for *Persistent Hypotension* is from 1400 to 1500. The blood pressure at 1410 was 95 over 55, and the blood pressure at 1445 was 85 over 50.

Noel Albritton: Select Value 2 (No) because there is a normal blood pressure followed by a low blood pressure.

This guidance for *Persistent Hypotension* states if two or more blood pressures are documented refer to the last two consecutive blood pressures within the hour. Select Value 2 if there is a normal blood pressure, followed by a low blood pressure. On our scenario on the previous slide, we had a blood pressure of 95 over 55 at 1410, then a blood pressure of 85 over 50 at 1445. Based on the guidance, we selected Value 2 (No) for *Persistent Hypotension* since there was a normal blood pressure followed by a low blood pressure. Let's take a look at another scenario.

Jennifer Witt: This *Persistent Hypotension* question asks: Which allowable value would you select for *Persistent Hypotension*? The hour to assess for persistent hypotension is from 1400 to 1500. The blood pressure of 95 over 55 is at 1410. A blood pressure of 85 over 50 is at 1445, and the MAR states that a vasopressor was given at 1600.

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Noel Albritton: Select Value 1 (Yes) because there is a normal blood pressure followed by a low blood pressure and *Persistent Hypotension* is unable to be determined, but a vasopressor was administered.

This 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 scenario on the previous slide had a blood pressure of 95 over 55 at 1410 and a blood pressure of 85 over 50 at 1445.

However, in this scenario, a vasopressor was also administered. Since there was a normal blood pressure followed by a low blood pressure and the vasopressor was administered, we selected Value 1 (Yes) in the scenario. Next, we would like your participation in the following question.

Jennifer Witt: Which allowable value would you select for *Persistent Hypotension* if there's a single blood pressure of 95 over 55 documented within the hour and a vasopressor was administered? A: Value 1 (Yes) persistent hypotension is present; B: Value 2 (No) or UTD, persistent hypotension not present; or C: Value 3 (No), persistent hypotension not assessed.

Noel Albritton: Select B which is Value 2 (No) for *Persistent Hypotension*. *Persistent Hypotension* is not present because there is a single normal blood pressure documented within the hour. The guidance related to persistent hypotension being unable to be determined and a vasopressor administered does not apply to the scenario because there is a single normal blood pressure documented within the hour to assess for *Persistent Hypotension*.

Jennifer Witt: Next, let's bring you a scenario for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. This question asks: Is this acceptable physician/APN/PA documentation attesting to performing a physical exam to select Value 1 (Yes) for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element? The heading states physical exam; skin, normal; cardiovascular, normal rate and rhythm; pulmonary, clear; genitourinary, incontinent.

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Noel Albritton: No. This is not acceptable physician/APN/PA documentation attesting to performing a physical exam. The documentation in this example includes the findings of a physical exam rather than documentation attesting to performing an exam.

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.

Physician/APN/PA documentation attesting to performing an exam would be physician documentation stating, “I performed a physical exam” or “a reassessment was performed.” A list of findings from a physical exam would not be physician/APN/PA documentation attesting to performing an exam. 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. The documented findings of a physical exam can be used to meet five of the eight parameters. In the scenario in the previous slide, findings such as the skin color would suffice the skin color or condition parameter. The guidance of the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element provides additional examples of physician/APN/PA attestation documentation.

That concludes our review of Q&As for manual version 5.9. Thank you for joining us. Candace, I will turn it back over to you

Candace Jackson: As stated at the beginning of today’s webinar, we will not be able to have a live Q&A session today

If your question was not addressed during the webinar, please submit your question to the [QualityNet Inpatient Question and Answer Tool](#) at the link on this slide. Next slide, please.

I will now turn the presentation back over to Noel who will go over how to submit your question to the Q&A tool. Noel, the floor is yours.

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Noel Albritton: Thank you, Candace. From the *QualityNet* CMS.gov website, you can search for existing questions and answers or submit a new question. To search for an existing Q&A, type the topic or data element into the search box and select Search. All Q&As pertaining to that topic will appear and you can review the existing Q&As to find your answer. The existing Q&As are for educational purposes.

It's important to ensure the Q&As you are referencing are in agreement with the current manual guidance based on the discharge period you are abstracting. We are continually reviewing and updating the existing Q&As, so it's also important to review the existing Q&As often to ensure the responses continue to apply to your questions. Also, from the *QualityNet* Q&A Tool page, you can submit your own question by selecting the Ask a Question button.

When submitting a question to the support team, you must complete the form which includes your name and contact information. The response to your question will be sent via email to the email address you include on this form.

You will next select the program. For abstraction questions for the SEP-1 measure, select Inpatient - Measures & Data Element Abstraction. Questions are often submitted to other programs by mistake, and it may take longer to get a response if your question has to be rerouted to the correct support team. For SEP-1 abstraction questions, the program to select is Inpatient - Measures & Data Element Abstraction.

After selecting the Inpatient - Measures & Data Element Abstraction program, you will then select the topic. For SEP-1 abstraction questions, you can select one of the topics under Hospital Inpatient - Sepsis. The topics listed are by data elements that are included in the SEP-1 measure.

The next required field is the Discharge Period. It's important to select the appropriate discharge period because answers to your questions may vary slightly depending on the manual version. Next, you will add the subject for your question in the Subject field.

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Then, enter your question into the Please Describe your Question field. It's important that no PII or PHI is included in your submitted questions. Also, we are unable to receive screenshots or attachments. Submitted questions should be concise and only include information specific to the topic being questioned. After you have entered your question, click the Submit Question button.

The support team will respond to your question as quickly as possible. That's how you can review existing questions and answers and submit a question to the support team. Candace, I will turn it back over to you.

Candace Jackson: Again, thank you, Noel and Jennifer, for the information that you provided today.

This event has been approved for one CEU. Credit can be obtained by clicking on the link on this slide. We'd like to thank you for joining our webinar today. We hope you have a great day.