Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock: Providence Tarzana Medical Center's Sepsis Journey and v5.4 Frequently Asked Questions

Questions and Answers

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July 17, 2018
2:00 p.m. ET

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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 may have been edited for grammar.

Question 1: **Slide 66. Can you abstract *Initial Hypotension* if the target intravenous fluids (IVF) are not given?**

Yes, you would still abstract *Initial Hypotension*. Only select Value "2" (No) if the target ordered volume completely infuses before the second hypotensive reading.

Example:
1300 - Blood Pressure 85/51
1345 - Severe Sepsis Presentation Time
1430 - Target ordered volume (30 mL/kg) of crystalloid fluids completes
1450 - Blood Pressure 82/48

Select Value "2" (No) for *Initial Hypotension* due to the target ordered volume completing before (1430) the *Initial Hypotension Time* of 1450.

Question 2: **Slide 73. Is the phrase Review of Systems (ROS) sufficient to answer yes to the focus exam question?**

Yes, physician/advanced practice nurse (APN)/physician assistant (PA) documentation of a "review of systems" completed would be sufficient to answer Value "1" (Yes) for the data element in question.

Question 3: **Does the entire 30 milliliters (mL)/kilogram (kg) fluid bolus need to be completed within six hours from presentation of septic shock? Or does it just have to be started?**

The target ordered volume of crystalloid fluids simply needs to be started within the specified timeframe.

Question 4: **Regarding the focused exam, does the physician need to enter a complete set of vital signs (VS) or does VS reviewed suffice? Does it matter if all the VS are by the same physician?**

There are multiple ways to meet this portion of the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element:

1. The same physician/APN/PA can document the blood pressure (BP), pulse, temperature, and respiratory rate in the same documentation.

2. The physician/APN/PA can document that they reviewed the vital signs.

Question 5: **If the crystalloid fluid is given in the timeframe, does it need to be at a rate > 125 mL/hour (hr)?**

Yes, acceptable crystalloid fluids are required to infuse at greater than 125 mL per hour. Crystalloid fluids running less than 125 or equal to 125 mL per hour cannot be used toward the target order volume.

Question 6: **Does infection or suspected infection have to be physician documentation? I thought it could also be nursing.**

Physician/APN/PA, nursing, or pharmacist documentation is acceptable for criteria A.

Question 7: **When a patient has two low BPs/mean arterial pressure (MAP) in the ambulance, do we enter the actual time or the emergency department (ED) arrival time for *Initial Hypotension*? Can we enter a time prior to arrival?**

For the blood pressures, when determining severe sepsis, you would use the taken or obtained time if documented. The ED arrival time would not be used.

Subject-matter experts researched and answered the following questions after the live webinar. This content may have been edited.

Blood Culture Collection

Question 8: **Slide 54. Based on the information in this slide, wouldn't this fail for blood cultures before antibiotics?**

Cases where the blood culture date and time is prior to antibiotic administration would meet the requirements and continue in the measure.

Question 9: **Slide 55. In this example, if severe sepsis is 7/1/2018 at 2100 and the antibiotic is given on 7/1/2018 at 0600, is that acceptable?**

Thank you for the question. The question needs further information in order to formulate an accurate response. Please follow-up via the *QualityNet.org* online tool at https://cms-ip.custhelp.com/app/home.

Question 10: **Slide 55. In this example, if severe sepsis is 7/1/2018 at 2100, the antibiotic is given on 7/1/2018 at 1800, and the blood culture is obtained on 7/1/2018 at 2000, is this an acceptable delay for blood cultures since severe sepsis not identified till after the antibiotic is hung?**

Yes, Value "1" (Yes) would be selected for the *Blood Culture Acceptable Delay* data element for the scenario you describe because both the blood culture collection and the intravenous (IV) antibiotic administration were before *Severe Sepsis Presentation Date and Time*.

Question 11: **Slide 56. In the example provided on the slide, what would be the acceptable timeframe for *Blood Culture Collection* for antibiotics that were started greater than 24 hours prior to the time of severe sepsis? For example, if a patient was started on IV antibiotics on 7/1/2018 at 1800, which he received daily, but did not meet severe sepsis criteria until 7/4/2018 at 1200, what would be the acceptable time frame for *Blood Culture Collection*?**

If the patient received an IV antibiotic within the 24 hours prior to *Severe Sepsis Presentation Time* and received the same IV antibiotic greater than 24 hours before the *Severe Sepsis Presentation Time*, the case would be excluded upon reaching the Broad Spectrum Antibiotic Timing calculation in the algorithm.

Antibiotic Administration

Question 12: **Slide 58. Is there a timeframe for documentation of the suspected causative organism? If the culture results are five days later, can that be used to answer antibiotic selection?**

The *Broad Spectrum or Other Antibiotic Administration Selection* data element does not specify a timeframe for when physician/APN/PA documentation must occur. Documentation of culture results five days after the antibiotic start time would not be acceptable.

Question 13: **Slide 58. If there is no physician documentation, can we look at lab cultures and the medication administration record (MAR) to meet those requirements?**

No, physician/APN/PA documentation is required.

Question 14: **Slide 59. In relation to slide 60, is the only difference in selecting Value "1" is that the clinician wrote susceptibility to vancomycin? Methicillin-resistant Staphylococcus aureus (MRSA) is commonly understood to be susceptible to vancomycin.**

Yes, Value "1" (Yes) is selected in the example on slide 60 due to the physician/APN/PA documentation, which includes the required components. Antibiotic susceptibility has to be determined by culture results.

Question 15: **For dual antibiotic therapy, where both antibiotics were given within three hours of presentation, what time will be abstracted? The first one or the second one?**

For the *Broad Spectrum or Other Antibiotic Administration Time* data element, if one or more antibiotics were started within the three hours after the presentation of severe sepsis, and the patient did not receive an antibiotic in the 24 hours before severe sepsis presentation, abstract the dose started closest to severe sepsis date and time.

Question 16: **Could you share Table 5.0 and Table 5.1 for appropriate intravenous (IV) antibiotics?**

Please refer to v5.4a of the *Specifications Manual for National Hospital Inpatient Quality Measures*, Appendix C, Table 5.0 and 5.1, located on *QualityNet.org* at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228776364473.

Question 17: **Is it correct to say that if the physician dictates that the infection is sensitive to vancomycin, then vancomycin, if given in the appropriate time frame, becomes appropriate as a monotherapy?**

No, Physician/APN/PA documentation has to reference culture results from within five days prior to the antibiotic along with other specified components (i.e., date of culture, the suspected causative organism, and the antibiotic to which it is susceptible). Then, if the IV antibiotic to which the organism is susceptible (e.g., Vancomycin) is administered within the specified timeframe, Value "1" (Yes) would be selected for the *Broad Spectrum or Other Antibiotic Administration Selection* data element.

Question 18: **I thought vancomycin was not adequate for severe sepsis as monotherapy except for in clostridium difficile?**

Intravenous vancomycin would also be acceptable if susceptibility to vancomycin is noted on culture results within five days prior to the antibiotic start time.

Question 19: **If a patient was on an antibiotic greater than 24 hours prior to the presentation time and a new antibiotic was administered after the presentation time, would the case be excluded?**

If an antibiotic was administered greater than 24 hours before the *Severe Sepsis Presentation Time* but not within the 24 hours prior to presentation, and a different antibiotic was administered within three hours after the *Severe Sepsis Presentation Time*, the case would not be excluded from the measure.

Crystalloid Fluid (CF) Administration

Question 20: **Slide 60. Are all antibiotics diluted with normal saline (NS)? Is this a given and we can just abstract the antibiotic volume?**

In order to use the fluids used to dilute a medication toward the target ordered volume, the order must include a crystalloid solution, volume, and rate or duration.

Question 21: **Slide 60. Do we combine the infusion volume when boluses of NS are infused at the same time as IV NS at 125 cubic centimeters (cc)/hr is being infused?**

No, infusion rates would not be combined. Each infusion applied toward the target ordered volume is required to infuse at a rate greater than 125 mL/hr.

Question 22: **Slide 60. Antibiotics diluted with NS can be used but should be an option since the intent of CF is for initial hypotension, initial lactic acid (LA) >4, or documentation of septic shock.**

Thank you for the comment. Per the current specifications, crystalloid fluids used to dilute a medication would be used toward the target ordered volume.

Question 23: **Slide 60. This does not seem realistic. Has CMS considered the complexity of calculations and expectations they are putting on clinicians? If there is a target volume of 30 cc/kilogram (kg) of CF, that should be sufficient to meet the intent of the measure and be the only abstracted date and time. I understand the goals of reducing fluid overload, but this is just not realistic to complete in the moment of treating these complex patients. I thought the allowance of fluids with antibiotics was purely to give credit when patients were just close to the cusp of meeting the volume total, not to make it a requirement to include this fluid volume.**

Thank you for the comment. To clarify, the expectation is not for clinicians to account for the fluids given with antibiotics when ordering fluids for the 30 mL/kg fluid resuscitation volume; as such a burden is not placed on clinicians. However, when there are multiple fluid orders (including medications diluted in crystalloid fluids) and greater than 30 mL/kg of crystalloid fluids are ordered, the abstractor would then perform the calculation to determine the completion time of the 30 mL/kg volume per the patient's documented weight.

Question 24: **Slide 62. Please give more examples of fluids running simultaneously but ending at different times. Please give an example with four bags of fluid as we see this often.**

Here is an example that includes four infusions.

Example:
Required target volume: 3400 mL
1. Order – IV NS 1000 mL over 1 hour – Start time 0940 = 16.67 mL per minute
2. Order – IV NS 1000 mL over 1 hour – Start time 1010 = 16.67 mL per minute
3. Order – IV NS 1000 mL over 1 hour - Start time 1030 = 16.67 mL per minute
4. Order – IV NS 1000 mL over 1 hour – Start time 1115 = 16.67 mL per minute

Infusion 1 - From 0940 to 1010 = 30 minutes x 16.67 mL/min = 500.1 mL

Infusions 1 and 2 - From 1010 to 1030 = 20 minutes x (16.67 + 16.67 mL/min) = 666.8 mL

Infusions 1, 2, and 3 – From 1030 to 1040 = 10 minutes (16.67 + 16.67 + 16.67 mL/min) = 500.1 mL

By 1040, 1667 mL were infused, 1733 mL remaining.

Infusions 2 and 3 – From 1040 to 1110 = 30 minutes x (16.67 + 16.67 mL/min) = 1000.2 mL

Infusion 3 – From 1110 to 1115 = 5 minutes x 16.67 mL/min = 83.35 mL

At 1115, 1733 mL – (1000.2 + 83.35 mL) = 649.45 mL remaining

Infusions 3 and 4 - From 1115 to 1130 = 15 minutes x (16.67 + 16.67 mL/min) = 500.1 mL

At 1130, 649.45 – 500.1 mL = 149.35 mL remaining

Infusion 4 – 149.35 / 16.67 mL/min = 9 minutes

1130 + 9 minutes = 1139 completion time of 3,400 mL

Question 25: **Slide 63. Requiring that type of calculation is hugely burdensome.**

Thank you for the comment. Calculating the completion time of the target volume is necessary in order to determine if hypotension persists following fluid resuscitation. Determining whether hypotension persists after fluid resuscitation is also critical for determining if *Vasopressor Administration* is required.

Question 26: **Slides 63 and 64. Even if 30 cc/kg are ordered, we have to see the administration documentation of crystalloids, in other words, when they were hung, correct?**

Correct, there must be a start time of the crystalloid fluids.

Question 27: **Slide 64. What if the provider orders fluids that are greater than 30 ml/kg? In other words, the target fluid volume is 2750 ml, but the provider orders 3000 ml. Is our completion time when the full 3000 ml is administered or when 30 ml/kg (2750 ml) is infused?**

Thank you for the question. In your example, the completion time would be when the 30 mL/kg volume (2,750 mL) is completed.

Question 28: **Slide 64. I was told by the *QualityNet* Question and Answer (Q&A) tool that you can count the fluids if they are run within 10 percent of the order. Please clarify.**

Crystalloid fluids that are ordered within 10% lower than the 30 mL/kg volume can be used in abstraction. If the 30 ml/kg volume is ordered, but only 90% of the 30 mL/kg volume is infused, Value "2" (No) would be selected.

Question 29: **Slide 64. The presenter stated, "using less than ordered amount is not acceptable." If the target fluid volume is equal to 2300 ml (and 90% = 2070 ml) and fluid orders are NS 1 liter (L) at 1200, NS 1L at 1300, and NS 1L at 1400, can we calculate the stop time at 2070 ml or at 2300 ml?**

With at least the 30 mL/kg volume ordered, the stop time would be calculated when 2,300 mL were completely infused.

Question 30: **Slide 64. It appears that there is no longer a within 10 percent range allowed; am I understanding this correctly?**

No, an order for within 10 percent of the target volume is still acceptable. If 30 mL/kg is ordered or a volume that is within 10 percent of 30 mL/kg is ordered, 100 percent of the fluid volume ordered must be infused. For example, if the target volume for the patient is 3,000 mL and the physician/APN/PA only orders 90 percent of 3,000 mL (2,700 mL), then that would be an acceptable order. That entire volume (2,700 mL) must be infused.

Question 31: **For a true septic patient that has crystalloid IVF resuscitation ordered at the correct dose but is at a lower rate per hour due to being a cardiac patient that cannot tolerate higher volume/rate of fluids, what is the correct option?**

If the rate is not greater than 125 mL/hr, the infusion would not be used toward the target ordered volume. Therefore, Value "2" (No) would be selected.

Question 32: **Can the combined crystalloid drip of greater than 125 cc/hr count toward the fluid bolus or does it have to be from one drip?**

No, infusion rates would not be combined. Each infusion applied toward the target ordered volume is required to infuse at a rate greater than 125 mL per hour.

Question 33: **Does the wording "completed" need to be used for fluid administration or does the order for the fluid work? If the order is acceptable, how do we know that they completed the fluid in a timely manner?**

No, documentation of "completed" is not required. However, the order for crystalloid fluids must include a rate, and documentation of fluid administration must include the start time. Infusion completion time would need to be determined based on the documented start time(s) and ordered rate(s) or end time(s).

Question 34: **Do we need to round fluids to whole numbers since you cannot run, for example, at 0.87 mL/minute?**

Yes, rounding the target ordered volume to the nearest whole number is acceptable.

Question 35: **Does the 30 ml/kg bolus have to be started within three hours but there is not a defined timeframe as to when it has to be infused by?**

Correct, the crystalloid fluids must be started within the specified time frame, but fluids are not required to be completed within a specified timeframe per the measure algorithm.

Question 36: **What if the physician orders more fluids than required for the 30 ml/kg; do you use the end of the physician ordered CF or do you calculate when the target for 30 ml/kg would have finished and use that?**

The completion time of the target ordered volume (30 mL/kg) would be calculated.

Question 37: **Is a longer time frame allowed for obese patients requiring large boluses of fluids?**

There is not a specified time frame in which the volume of fluids must be completely infused by. The fluids must be started within three hours of identifying initial hypotension or septic shock and must be infused at a rate > 125 mL/hr.

Question 38: **If the order for 30 mL/kg is started within the required timeframe, but the total volume is not completed due to development of pulmonary edema, will this data element still pass?**

If the total volume is not completed, it will not pass. The target ordered volume needs to be completely infused in order to pass.

Question 39: **Why is it only specified to abstract fluids three hours after *Initial Hypotension* when that's the requirement for compliance? We were told to look for fluids any time after septic shock or lactate > 4.**

Crystalloid fluids started within six hours prior through three hours after *Initial Hypotension* or septic shock (*Initial Lactate Level Result* >=4 or *Documentation of Septic Shock*) are acceptable.

Question 40: **Often our practitioners administer the target crystalloid fluids before hypotension presentation. When I review the BPs in the timeframe after IVF administration the blood pressures are normal, and the hypotension occurs later. Do they need to administer the target crystalloid fluids again to pass the measure?**

If the initial target volume of crystalloid fluids was administered within six hours prior through three hours after *Initial Hypotension* or the *Septic*

Shock Presentation Time, the target volume of crystalloid fluids would not need to be administered a second time. However, if the initial target volume of crystalloid fluids was not started within the timeframe for fluid administration, further fluid administration within the specified timeframe would be required.

Question 41: **For fluid administration, can we use the ideal weight of the patient versus the actual weight, especially when treating obese patients with or without heart failure?**

If there is physician/APN/PA documentation that the patient is obese or body mass index (BMI) >30 and there is clear physician/APN/PA documentation that the ideal body weight will be used to determine the target ordered volume, the ideal body weight can be used in abstraction.

Question 42: **The patient was given one liter of NS; the patient needs 2100 cc. The physician then ordered NS at 150 cc/hr. Can we calculate 1100 cc from the second order of NS at 150 cc/hr to complete the 2100 cc requirement?**

If there is a complete order, which includes a total volume for the fluids infusing at 150 mL/hr and the infusion is started within the timeframe, it would be acceptable. The completion time of the target ordered volume would be calculated based on when the remaining 1100 mL is infused from the NS running at 150 mL/hr.

Question 43: **Do we need to document the time the 30 mL/kg fluid is infused in the medical record or is it acceptable to just calculate it outside the medical record for abstraction purposes?**

For abstraction purposes, the abstractor should use what is documented in the medical record to calculate the target ordered volume completion time. The abstractor would not document their calculation in the medical record.

Question 44: **When calculating the IV fluid completion time, do we have to use the documented completion time by nursing if this is documented in the medical record? It is usually not accurate when compared to the order and may represent when nursing had time to document the completion of the IV fluids instead of the actual time it was completed.**

Use the rate, duration, or end time the fluids were actually administered over, along with the start time to calculate the completion time.

Question 45: **Do the antibiotics infused have to be in NS or one of the other listed fluids to be able to be counted towards the crystalloid fluid bolus? Antibiotics in Dextrose 5% in Water (D5W) would not count, correct?**

Correct, only medications diluted in a crystalloid or balanced crystalloid solution are acceptable.

Question 46: **If counting the solution added to antibiotics, does that fluid need to be running at > 125 ml/hr?**

Yes, only crystalloid fluids infusing at greater than 125 mL/hour would be used towards the target ordered volume.

Question 47: **If the patient has documentation of jugular venous distention (JVD) is that an acceptable reason to not complete the required fluid volume?**

The example provided would not be an acceptable reason to not complete the required fluid volume.

Comfort Care

Question 48: **Slide 65. Is an order for a palliative care consult all that is necessary to answer Value 1 (yes)? For example, if the palliative care consult is ordered and completed within the timeframe and the patient chooses to continue full care and refuses hospice or palliative care, should Value "1" still be chosen?**

Yes, the physician/APN/PA order for palliative care consult within the specified timeframe would suffice for selecting Value "1" (Yes) even with further documentation as outlined.

Question 49: **If the physician documents "comfort measures only" in a note and no order is written, can we use that to abstract "Yes" for comfort measures?**

Yes, physician/APN/PA documentation of a recommendation, plan, order, or referral for "comfort measures only" within the specified timeframe is acceptable.

Initial Hypotension

Question 50: **Slide 67. Wouldn't the hypotension recorded at 10:00 be considered *Initial Hypotension*, but would not be eligible to be used to establish *Persistent Hypotension*?**

Since *Initial Hypotension* requires two hypotensive blood pressures within the timeframe, the single hypotensive reading at 10:00 alone would not suffice for *Initial Hypotension*.

Question 51: **For *Initial Hypotension*, is it within six hours before or within six hours after, or is it two low BPs within the whole twelve-hour span?**

The timeframe for *Initial Hypotension* includes 12 hours; which are six hours prior through six hours after the *Severe Sepsis Presentation Time*.

Question 52: **If a patient has *Initial Hypotension* but does not have documented septic shock by a physician/APN/PA, it instructs you to stop abstracting. Is this correct?**

If Value "1" (Yes) is selected for *Initial Hypotension*, the case will continue in the algorithm. Only if Value "2" (No) is selected for *Initial Hypotension* and the *Initial Lactate Level Result* is less than 4 would abstraction stop upon reaching the *Documentation of Septic Shock* data element.

Question 53: **Normally, all criteria need to be met within six hours. If there is a low BP four hours prior to qualifying for severe sepsis, and the second low BP is eight hours later, would you still answer "Yes" to hypotension?**

If the two hypotensive BP readings are within the timeframe specified in the data element, Value "1" (Yes) would be selected for *Initial Hypotension*.

Persistent Hypotension

Question 54: **Slide 70. We have had failures where in the example we would have had the BP be normal at 1500, be low at 1514, and then be normal again at 1520. Since the hour was up at 1515 the case failed. Why was this changed for version 5.4 from previous examples, as we did follow up on the BP and "ran out of time" on the hour?**

The update in version 5.4 was meant to evaluate the latest blood pressures in the hour to more accurately determine if hypotension persisted. While at times a single hypotensive blood pressure reading will occur on the last minute of the hour, this is typically an outlier scenario rather than the norm.

Question 55: **Slide 70. Will the data element fail if there is not enough time left within the hour following the completion of 30 mL/kg to determine *Persistent Hypotension*? For example, the one-hour time window is from 1400-1500; 1415 BP is 98/60, 1430 BP is 95/60, 1500 BP is 87/56. This leaves no time left to check another BP.**

Yes, if the last blood pressure recorded in the hour is hypotensive, Value "3" (No) would be selected.

Question 56: **Slide 70. What if the BP following the last two of the hour (with frequent BP checks) is normal? But we are clearly outside the hour window?**

Only blood pressure readings documented within the one-hour timeframe would be used to determine *Persistent Hypotension*.

Question 57: **Slide 71. What if the last two BPs taken were at the end of the one-hour timeframe? There would be no further opportunity for the hospital to pass the metric if unable to take the vital signs from the following hour. What is the plan to take this scenario into account?**

If the last BP recorded in the hour is hypotensive, Value "3" (No) would be selected. Only BP readings documented within the one-hour timeframe would be used to determine *Persistent Hypotension*.

Question 58: **Slide 71. If the single hypotension is at the last minute of the hour after fluid bolus infused, how can we expect to have another reading? We are not allowed to abstract a BP that occurs after this hour. We could very well have obtained a recheck but will not get credit for it since we cannot abstract a reading found outside that hour. This leads to unfair compliance scores.**

For *Persistent Hypotension*, if multiple blood pressures are documented within the hour following the completion of the target volume of crystalloid fluids, refer to the last two blood pressures documented within the hour. If there are two consecutive hypotensive readings at the end of the hour, Value "1" (Yes) would be selected. The update in version 5.4 was meant to evaluate the latest blood pressures in the hour to more accurately determine if hypotension persisted. While at times a single hypotensive blood pressure reading will occur on the last minute of the hour, this is typically an outlier scenario rather than the norm.

Question 59: **Slide 71. Then by definition, if we are continuing to assess the patient after the *Persistent Hypotension* window, shouldn't it count as "Yes" (Value 1)? The purpose is to take care of the patient appropriately. Continuing to monitor the BP is the best practice.**

Only blood pressure readings documented within the one-hour timeframe would be used to determine *Persistent Hypotension*.

Question 60: **Slide 71. You stated, "hypotensive readings must be followed up on." Please elaborate on how this may or may not affect how we answer the *Persistent Hypotension* question.**

If a hypotensive reading is documented, a follow-up blood pressure would be required to determine if hypotension persists. If a single hypotensive reading is not followed-up on, Value "3" (No) would be selected.

Question 61: **For *Persistent Hypotension*, if the hour after IVF starts at 1300 and you have one normal and one hypotensive reading, then do you abstract Value 3? What if the revisit of the hypotensive VS is after the one hour? There is no miss to the core measure, the patient just had one normal**

and one abnormal VS. Please explain the rationale for calling this a miss?

If the last blood pressure recorded in the hour is hypotensive, Value "3" (No) would be selected. Only blood pressure readings documented within the one-hour timeframe would be used to determine *Persistent Hypotension*. The update in version 5.4 was meant to evaluate the latest blood pressures in the hour to more accurately determine if hypotension persisted. While at times a single hypotensive blood pressure reading will occur on the last minute of the hour, this is typically an outlier scenario rather than the norm.

Question 62: **For the *Persistent Hypotension* update. For example, *Persistent Hypotension* needs to be assessed from 1400 to 1500. We have a value at 1415 of 100/60, value at 1430 of 102/58, and at 1500 a value of 88/50. What happens in this situation when the last possible value within the timeframe is hypotensive since we cannot go beyond the 1500 timeframe?**

If the last blood pressure recorded in the hour is hypotensive, Value "3" (No) would be selected. Only blood pressure readings documented within the one-hour timeframe would be used to determine *Persistent Hypotension*.

Question 63: **Should fluids be completed for hypotension prior to vasopressors being administered?**

The measure does not require the completion of crystalloid fluids prior to the administration of vasopressors.

Question 64: **How is *Persistent Hypotension* reassessed if the target fluid volume is not completed and Levophed (vasopressor) has already been started? The Levophed can't be stopped to assess for hypotension.**

Persistent Hypotension can still be assessed in the hour after the completion of the target ordered volume of crystalloid fluids regardless of whether vasopressor administration has begun.

Question 65: **I am unclear why the measure bundle does not "fall out" if after the patient has been determined to have *Initial Hypotension* and NS 30 ml/kg has been given, but then no BP is obtained in the one hour following to determine *Persistent Hypotension*. We have this happen,**

but when entering into the software vendor tool it does not make it a "fall out." It only completes the abstraction and just considers the patient as not having *Persistent Hypotension* instead of falling out due to not completing the needed functions of the bundle, such as the one hour post BP.

If no blood pressures were documented within the hour, Value "3" (No) would be selected. This selection would cause the case to "fall out" of the numerator population. If your abstraction tool follows a different route after selecting Value "3" (No), please follow-up with your vendor.

Question 66: **We have been led to believe that we should not use BPs prior to arrival in ambulances as this would be difficult. Would this also apply to BPs taken in urgent care settings prior to arrival?**

Vital signs documented in pre-hospital records that are included in the medical record are acceptable.

Question 67: **How can we be required to say the patient was not assessed for *Persistent Hypotension* when the BP is being documented every five minutes and all were normal except the very last one? Twelve BPs were documented; they were assessing the patient. This doesn't seem fair.**

For *Persistent Hypotension*, if multiple blood pressures are documented within the hour following the completion of the target volume of crystalloid fluids, refer to the last two blood pressures documented within the hour. If there are two consecutive hypotensive readings at the end of the hour, Value "1" (Yes) would be selected. The update in version 5.4 was meant to evaluate the latest blood pressures in the hour to more accurately determine if hypotension persisted. While at times a single hypotensive blood pressure reading will occur on the last minute of the hour, this is typically an outlier scenario rather than the norm.

Question 68: **Am I correct that two blood pressures must be documented in the hour after crystalloid administration?**

In order to select Value "1" (Yes) for *Persistent Hypotension*, two consecutive hypotensive blood pressure readings at the end of the hour following the completion of crystalloid fluids are required.

Repeat Volume Status

Question 69: **Slide 73. If there are imported vital signs to the history and physical (H&P) that state the peripheral pulse heart rate (HR) is 73, is that sufficient to say "yes" to peripheral pulse evaluation performed?**

With the documentation indicating the HR is a peripheral pulse, the documentation would suffice the peripheral pulse parameter within the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element.

Question 70: **Slide 73 seems to contradict slide 72. Additionally, I thought the specific elements of the focused exam (slide 72) were no longer required and evidence that a physical exam was performed is acceptable to pass this element. Please clarify.**

The new data element allows for multiple options; hence this is not a contradiction but just a demonstration of the different options available. Specific elements of the focus exam are no longer required; however, abstractors still have the option of abstracting them in case an attestation of a physical exam being performed is not present in the data element.

Question 71: **If there is a "Physical Exam" or "Review of Systems" section on an H&P or progress note, does that suffice to meet the requirements for *Repeat Volume Status and Tissue Perfusion Assessment Performed*, or does the physician have to actually state in the note that he performed a physical exam or review of system?**

Physician/APN/PA documentation indicating or attesting to performing an exam is required. The title or heading "Physical Exam" or "Review of Systems" without documentation or attestation would not suffice.

Question 72: **We have "PHYSICAL EXAMINATION" as a header in our progress notes. If the physician documents "Physical examination: (appears with a description of the patient's condition)," is this sufficient? Or would that second documentation of physical examination be considered a header?**

Physician/APN/PA documentation indicating or attesting to performing an exam is required. The title or heading "Physical Exam" or "Review of Systems" without documentation or attestation would not suffice.

Question 73: **If there is a nursing documentation of the patient's hemodynamics, such as stroke volume, cardiac index, etc. in the flowsheet, can this be counted as a tissue perfusion assessment?**

Documentation of these variables alone is not sufficient as a tissue perfusion assessment.

Severe Sepsis

Question 74: **Slide 75. Is "would not be excluded" a typo? I interpret the response to be that the platelet count of 75 would not be used.**

We apologize for the typo. The slide should read that "Only the platelet count of 75 would be excluded."

Question 75: **Slide 75. If the physician documented that the platelets of 75 were related to the patient having chronic hepatitis C, and this was the normal range for this patient, would this be appropriate documentation to disregard all low platelet counts?**

If the platelet count is documented as due to a chronic condition, the abnormal platelet value(s) would not be used.

Question 76: **Slide 76. Do I understand that documentation of a seizure is considered a source of infection? Many seizures have nothing to do with infections. Do I understand that the physician needs to include the reason for the seizure in order not to use it as an organ dysfunction?**

The "seizure" is not considered the source of infection, but rather the acute condition. To not use the sign of organ dysfunction, further documentation indicating the acute condition (seizure) is due to a non-infectious source is required.

Question 77: **Slide 77. The slide states that with Xarelto being listed under the home medications, you should not use the elevated international normalized**

ratio (INR). However, in the specifications manual, it says the signs of organ dysfunction should be used because they're on different locations in the note.

If an anticoagulant from Table 5.3 is documented on the home medication record or as given in the hospital, the abnormal INR or activated partial thromboplastin time (aPTT) values would be disregarded.

Question 78: **Slide 78. If a patient has a noted history of atrial fibrillation (Afib) but it is clearly documented that the patient is in normal sinus rhythm or sinus tachycardia, confirmed by an electrocardiogram (EKG) during the time of the abnormal HR, can we still use the HR for systemic inflammatory response syndrome (SIRS) criteria?**

Yes, the elevated heart rates would be used.

Question 79: **Slide 78. Previous guidance stated if the patient is diagnosed with Afib with rapid ventricular response (RVR) all heart rates are excluded. The manual also states this. It is not mentioned that it has to be labeled as chronic. Is this new for July 1, 2018 discharges? Where can I find this guidance in the manual?**

Guidance within the *Severe Sepsis Present* data element allows for elevated heart rates (i.e., tachycardia or RVR) to not be used if documented as due to a chronic condition. Therefore, if A-fib is documented as a chronic condition, the elevated heart rates attributed to the chronic condition would not be used.

Question 80: **Slide 79. How would you abstract if there was no physician documentation of influenza but there was a positive lab result for influenza?**

Abstraction would continue without regard to the positive influenza lab result.

Question 81: **Slide 79. What if on 7/15/2018 at 0900 in a note the physician states severe sepsis related to bacterial infection. Do we use the 7/15/2018 at 0900 since the first documentation of severe sepsis viral was 7/15/2018**

at 0800? I see contradicting documentation by different doctors multiple times.

The first documentation of "severe sepsis viral" at 0800 would be disregarded, and Value "1" (Yes) would be selected for *Severe Sepsis Present* based on the documentation of severe sepsis at 0900.

Question 82: **Slide 79. With severe sepsis being documented due to Influenza on 7/15/2018, why isn't this considered the first presentation? Since we are abstracting the first episode presentation, then we would stop abstraction due to connecting the severe sepsis with a virus. Is it correct that I would not abstract any further because it would be the second episode?**

Abstraction would continue as the documentation of "Severe Sepsis due to influenza" would not be considered the first presentation, because the measure specifications indicate to exclude documentation of viral infections.

Question 83: **Slide 80. If severe sepsis wasn't present at that time of the PA documentation, why wouldn't we keep going and use the physician documentation of septic shock?**

If severe sepsis was not met prior to the physician/APN/PA documentation of "patient not septic," abstraction would continue, and the documentation of septic shock would be abstracted.

Question 84: **Slide 80. I would have used the 7/5/2018 at 1300 as the date and time for severe sepsis and septic shock. I'm not in agreement with your answer. Just because the physician stated that the patient was not septic at 1200 doesn't mean that the patient can't become septic at a later date and shouldn't count.**

Thank you for the comments. You are correct; however, for the purposes of the measure, those types of situations are not currently being considered.

Question 85: **Slide 80. I thought the documentation needed to say "patient is not severe sepsis," not just "patient not sepsis."**

For manual version 5.4, the documentation of "not septic" is acceptable if documented within six hours after the *Severe Sepsis Presentation Time*.

Question 86: **Slide 80. Wouldn't the documentation at 7/5/2018 at 12:00 make the first episode of severe sepsis/septic shock at 7/5/2018 at 13:00?**

The first presentation of severe sepsis would be 0800 based on meeting the clinical criteria.

Question 87: **Slide 80. I would not have thought that the documentation of not septic followed by septic shock should be excluded.**

Just to clarify, the situation in the slide is severe sepsis and not septic shock. Value "2" (No) would be selected for *Severe Sepsis Present* due to the documentation of "patient not septic" within six hours after the earliest *Severe Sepsis Presentation Time*. In essence, this documentation negates the established clinical criteria and creates a level of complexity which is beyond what is being targeted for measurement.

Question 88: **Slide 80. The guidance on this slide contradicts slide 79 by saying that you would only abstract the first episode of severe sepsis. It is almost the same thing as slide 70, saying the severe sepsis did not exist due to influenza and then you say it does because the doctor said septic shock but, in this case, (slide 80) you say the exact opposite. Please clarify**

Both slides follow the guidance provided in the data element.

On slide 79, severe sepsis is first specifically attributed to influenza, which is ignored. The later documentation of septic shock is then used because it is a more general statement and not connected to a particular source, unlike the earlier documentation.

On slide 80 however, severe sepsis is first met by clinical criteria, then there is documentation stating the patient is not septic. In essence, this documentation of "not septic" negates the established clinical criteria. Therefore, Value "2" (No) is selected because the presence of severe sepsis is negated.

Question 89: **Slide 80. Why is 1300 not the new time zero since it's within six hours of initially meeting severe sepsis?**

Just to clarify, the situation in the slide is severe sepsis and not septic shock. Value "2" (No) would be selected for *Severe Sepsis Present* due to the documentation of "patient not septic" within six hours after the earliest *Severe Sepsis Presentation Time*. In essence, this documentation negates the established clinical criteria and creates a level of complexity which is beyond what is being targeted for measurement.

Question 90: **Slide 80. For the example regarding criteria met at 0800, PA documentation at 1200 of not septic, and then septic shock at 1300. Given you can't have septic shock without severe sepsis and it's all within six hours, isn't that conflicting documentation?**

Thank you for the question. You are correct; however, for the purposes of the measure, those types of situations are not currently being considered.

Question 91: **Slide 80. It was our understanding that if a patient had a, b, c criteria (or severe sepsis was documented) and was then found to not be septic, we would still need to look further into the medical record to see if the patient became septic again and we would then use the next a, b, c criteria (or if severe sepsis is documented). Is this a change from previous versions?**

Thank you for the question. In specification manual version 5.4, if the patient meets *Severe Sepsis Present* clinical criteria and within six hours after meeting criteria there is physician/APN/PA documentation indicating the patient is not septic, Value "2" (No) would be selected.

Question 92: **Slide 81. Many times, there is a back log of bed requests and the patient is left waiting in the ED. If we use the time of admission to the unit, when there is documentation of present on admission, this may be hours later and skew the timing of the elements. What can we do in these cases?**

With the current specifications manual, for severe sepsis documented as "present on admission," you would continue to abstract the earliest arrival

time to the inpatient floor or unit for admission. We are looking into this further for future versions of the manual.

Question 93: **Slide 81. How can a provider predict that the patient will have severe sepsis present four hours and 15 minutes in the future? The manual states to use the earliest documentation and the physician documentation time is prior to the admission time.**

With the current specifications manual, for severe sepsis documented as "present on admission," you would continue to abstract the earliest arrival time to the inpatient floor or unit for admission. We are looking into this further for future versions of the manual.

Question 94: **Slide 81. What if the documentation states severe sepsis present on arrival versus admission?**

In this example, you would abstract the earliest documented arrival time to the hospital.

Question 95: **Slide 81. This guidance applies only if there are no earlier clinical criteria for severe sepsis, correct?**

Correct, if the clinical criteria were met earlier, the earlier *Severe Sepsis Presentation Time* would be abstracted.

Question 96: **Is altered mental status (AMS) an indicator for organ dysfunction for the sepsis measure?**

No, altered mental status is not one of the criteria for measure.

Question 97: **Regarding MAP. If the nurse just documented the BP reading, not the MAP, should the MAP be calculated and interpreted as <65? Or should we only accept the data when a MAP is actually documented? For example, the nurse documented BP 101/34; however, MAP isn't documented, which should be 56 by calculation. Would we use the calculated MAP?**

Use the value documented in the medical record. The abstractor should not calculate the MAP.

Question 98: **The patient was placed on a ventilator with the rate set at 22. While ventilated, the patient has various respiratory rates of 22, 21, and 31. Would we consider any of these readings or would they all be excluded?**

With the artificial intervention set at 22, the respiratory rate of 31 would be used for SIRS criteria.

Question 99: **How are the clinicians determining time zero? Are they using triage time? If not, how do they determine it? Secondly, how do you achieve high compliance with the repeat lactate?**

The *Severe Sepsis Presentation Time* is determined by all three clinical criteria being met or documentation of severe sepsis or septic shock. The triage time is not used. Please refer to the *Severe Sepsis Presentation Time* data element for further specific guidance.

To be compliant with the *Repeat Lactate Level Collection* data element, a lactate must be collected after the *Initial Lactate Level Collection* and within six hours after the *Severe Sepsis Presentation Time*.

Question 100: **For SIRS criteria to be used, do you need to have two consecutive BP readings?**

Evidence of organ dysfunction (*Severe Sepsis Present* criteria C) only requires one hypotensive blood pressure reading.

Question 101: **This is a sepsis patient with *Initial Hypotension* and 30 ml/kg of fluid bolus was given according to the measure. There was no *Persistent Hypotension* after one hour of fluid bolus being given, but later on, and within the six hours after severe sepsis presentation, the patient dropped the BP again. What is the proper treatment?**

If Value "2" (No) was selected for *Persistent Hypotension*, abstraction would continue. The hypotensive BP readings documented after the one-hour timeframe to assess for *Persistent Hypotension* would not be used.

Question 102: **Is nursing documentation of checking "Yes" on a checklist for "suspected infection, source unknown" acceptable?**

Yes, the selection of Value "1" (Yes) for "suspected infection, source unknown" would be acceptable.

Question 103: **The patient presents to the ED meeting sepsis criteria (has a positive SIRS and source of infection) at 0800 in the morning but the lactate is normal, and then develops severe sepsis at 2000 in the evening with a lactate of 2.5. When should the abstraction period start?**

Value "1" (Yes) would only be abstracted in this scenario when all three clinical criteria are met within six hours of each other.

Question 104: **If a physician documented "creatinine elevation due to dehydration," but within 24 hours a different physician documented "elevated creatinine likely due to infections," do we use those elevated creatinine levels as a sign of organ dysfunction?**

Yes, a sign of organ dysfunction documented as due to dehydration (acute condition) or due to an infection would be used.

Severe Sepsis Date and Time

Question 105: **Slide 81. For the example, you would not consider ED presentation?**

Because the example shows presence of severe sepsis is based upon physician documentation of "severe sepsis present on admission," you would abstract the earliest arrival time to the inpatient floor or unit for admission.

Question 106: **Slide 81. If a patient has admission orders, but remains in the ED awaiting an inpatient bed, what time is considered the admission time?**

Because the example shows presence of severe sepsis is based upon physician documentation of "severe sepsis present on admission," you would abstract the earliest arrival time to the inpatient floor or unit for admission.

Question 107: **With regards to the physician charting of severe sepsis present on admission, can "POA" be considered as present on admission?**

Because "POA" can mean present on arrival or present on admission, if severe sepsis is only documented in the note as "POA," use the date and time the note was started or opened. If severe sepsis was documented multiple times within a note, which includes documentation of "POA," use the earliest time specified for the documentation of severe sepsis.

Question 108: **Are you saying that we are taking physician documentation from 4.5 hours prior to receipt into a patient room as our time of presentation? That makes little sense because the ED likely has already met the criteria that meet the measure; this is setting organizations up to fail.**

Presentation time is based on the specificity of the documentation. It should be based on the earliest time there is documentation indicating severe sepsis is present, whether it is clinical criteria met or clinician documentation. If clinical criteria are met in the ED prior to admission the time clinical criteria in the ED are met should be used. In the absence of presentation occurring prior to admission time, if the physician/APN/PA documents severe sepsis is "present on admission" it should be abstracted at face-value. Meaning, abstract the time that reflects when the patient was admitted to the hospital. We would not infer that severe sepsis was present at another time such as on arrival to the ED or when the admission order was written. If the earliest documentation indicting the patient has severe sepsis is in a physician note but does not include a time in the note associated with when severe sepsis was identified the time the note was started or opened should be used.

Question 109: **The physician documents severe sepsis with shock but there is no time stamped. We don't have a note open time. On the top of the note there is a time, but it is always the arrival time. If I go by the time when the last criterion was met, my severe sepsis presentation time is later than the septic shock time. It is well within six hours though. Is this acceptable?**

If the documentation of severe sepsis is untimed, it cannot be determined to be the earliest *Severe Sepsis Presentation Time*. Therefore, continue to abstract for the earliest *Severe Sepsis Presentation Time*. The *Severe Sepsis Presentation Time* cannot be later than the *Septic Shock Presentation Time*. If septic shock was documented by the physician/APN/PA, the time of this

documentation would also be the *Severe Sepsis Presentation Time*. If septic shock was met by clinical criteria, the time at which the last criterion meeting severe sepsis would be used for the *Septic Shock Presentation Time* as well.

Question 110: **Why would you rely on when a patient is transferred to a floor/unit for the severe sepsis time, if it is documented upon arrival? The time clock should start ticking as soon as the physician documents it.**

If the physician documented severe sepsis is present on arrival, then use the earliest documented arrival time.

Question 111: **Why wouldn't the admission to inpatient status be accepted rather than the admission to the floor?**

For purposes of the measure, the documentation of "present on admission" is abstracted at face-value. Meaning, abstract the time that reflects when the patient was admitted to the hospital. We would not infer that severe sepsis was present at another time such as on arrival to the ED or when the admission order was written.

Question 112: **How would you abstract if the patient went to the ED, then to the operating room, and then was admitted inpatient post-op, but severe sepsis is documented as present on admission; which time would you use?**

Per the guidance for the *Severe Sepsis Presentation Time* data element you would use the earliest documented hospital observation/inpatient admission time. This would be the point the patient arrives on the inpatient unit.

Other Abstraction Questions

Question 113: **We have a lot of trouble with the measure that states the lactic acid closest to the time zero is the initial one. How many lactic acids do you do and at what intervals?**

The measure requires an initial lactate to be collected within six hours prior through three hours after the presentation of severe sepsis. If the initial lactate is greater than 2 millimole (mmol)/L, a repeat lactate must be collected within six hours of *Severe Sepsis Presentation*.

Question 114: **How can you have septic shock without severe sepsis?**

In order to abstract Value "1" (Yes) for *Septic Shock Present*, Value "1" (Yes) must be selected for *Severe Sepsis Present* first.

Question 115: **Can you provide the time frames for auditing each of the following elements? Is it:**

- **First Lactic Acid (LA) six hours before to three hours after**
- **Blood culture 24 hours before or is it 48 hours before to three hours after**
- **Antibiotics 24 hours before to three hours after**
- **Fluid bolus six hours before to one hour after initial hypotension or LA >4**

The timeframe for the collection of the initial lactate is six hours prior through three hours after the *Severe Sepsis Presentation Time*.

The timeframe for *Blood Culture Collection* is dependent on the IV antibiotic. If an IV antibiotic is not administered within the 24 hours prior to severe sepsis, the blood culture timeframe would be 24 hours prior through three hours after the *Severe Sepsis Presentation Time*. If an IV antibiotic was administered within the 24 hours prior to severe sepsis, the blood culture timeframe would be 24 hours before the antibiotic through three hours after the *Severe Sepsis Presentation Time*.

An IV antibiotic must be administered within the 24 hours prior through three hours after the *Severe Sepsis Presentation Time*.

Crystalloid fluids started six hours prior through three hours after *Initial Hypotension* or septic shock is acceptable.

Question 116: **The SEP-1 present on admission rule does not coincide with CMS definition of admission. The admission time for CMS is date/time of admit order, why doesn't SEP-1 follow the CMS guidelines for admission time?**

The *Admission Date* data element serves as one of the determining factors for identifying the measure population. The *Admission Date* data element

does not provide guidance for the abstraction of the *Severe Sepsis Presentation Date or Time*.

Other/Comments

Question 117: **Slide 52. Do you have any idea when the benchmarks will be published?**

The benchmarks for the SEP-1 measure were published on *QualityNet.org* on July 26, 2018: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228768205297

Question 118: **I think it would be very beneficial if the SEP-1 measure could include the performance of each individualized metric within the bundle (e.g., initial lactic acid, blood culture before antibiotics, broad spectrum antibiotic, etc.) instead of hospitals having to manually calculate each metric. My vendor only supports the bundles. Are there any thoughts of individualizing the metrics (similar to AMI or Stroke) in addition to the bundle?**

Thank you for your comments. Currently, there are no plans to individualize the metrics within the bundles. However, we will take your suggestion under consideration.

Question 119: **We have over a dozen hospitals in our system, and multiple people who abstract the sepsis measure. Sometimes we collaborate to resolve difficult abstraction questions. On more than one occasion we've discovered that we've submitted nearly identical queries to the *QualityNet* Q&A system but received contradictory responses. How do you recommend we proceed through situations in which we receive differing abstraction guidance from the *QualityNet* Q&A forum?**

Please follow-up with us via the *QualityNet* online Q&A tool whenever you feel as though you have received contradictory responses. When reaching out to us regarding perceived contradictory guidance, we recommend that you clearly identify where you believe a contradiction exists, so we can promptly clarify the issue at hand.

Question 120: **What is the best way for a physician to contact CMS regarding their concerns related to elements in the SEP-1 measure?**

Comments and questions should be submitted via the *QualityNet.org* online Q&A tool which is then forwarded to the appropriate personnel.

Question 121: **I recently read that the Surviving Sepsis Campaign recently revised the three and six-hour bundles into a one-hour bundle. Will CMS be updating the measure to reflect the change?**

CMS and the measure stewards are reviewing the Surviving Sepsis Campaign Bundle 2018 Update, which introduces a 1-hour bundle to replace the 3-hour and 6-hour bundles. Continue to abstract for SEP-1 based upon the version of the specifications manual that is designated for the period within which the cases you are abstracting were discharged.

Question 122: **I would like to email Noel to clarify something he stated in this version of updates. Does he have a contact email?**

Please submit your question or comment via the *QualityNet.org* online Q&A tool.

Question 123: **Give the fluids and then reevaluate. No one reevaluates in the middle of a liter of fluid or takes antibiotic fluids into account in actual patient care. Finish the bolus then reevaluate.**

The specifications manual allows for assessment of volume status during the administration of fluids which is in line with clinical best practices.

Question 124: **This is the worst measure ever. Shame on CMS. I feel like no one high up even really knows what the data abstraction requirements are or they'd put a stop to it. I've abstracted lots of core measures, and this is one is an outlier. It's just terrible.**

Thank you for sharing your concerns regarding the SEP-1 measure. CMS recognizes the burden imposed by this measure in the pursuit of the Hospital Inpatient Quality Reporting (IQR) Program's goal of improving quality of care through transparency and public disclosure of quality data. As part of the CMS Meaningful Measures framework, we strive to focus on areas

addressing the highest priorities for quality measurement and improvement, which entails assessing only those core issues that are the most critical to providing high-quality care and improving individual outcomes. The SEP-1 measure is included in the Hospital IQR Program because we believe it addresses such an issue. Nonetheless, we are always considering opportunities to make existing measures less burdensome.

Please feel free to submit feedback on specific data elements which are of concern via *QualityNet.org*. CMS, the Measure Stewards, and measure writers continue to focus on improvements to the measure, as well as abstractor burden when considering updates to the SEP-1 measure.

Question 125: **Will CMS have a live, interactive; back and forth dialogue Q&A with abstractors? I think this would be beneficial for the most accurate understanding and abstraction of the measure.**

Thank you for your input. A live Q&A with abstractors is not currently planned. However, we will add this suggestion for consideration in the future.

Question 126: **This measure gets worse and worse.**

Thank you for your comments. Please contact us via the *QualityNet.org* online Q&A tool to share the issues.

Question 127: **In general, how would you say CMS validation abstractions are going? Are you seeing more matches or mismatches?**

Thank you for the question. While specific details about validation results are not publicly available, we can share that, based on past validation results, the majority of sepsis measure cases matched and passed validation.

Question 128: **Excellent presentation by the team at Providence! Would love it if CMS would set up more educational webinars from other hospitals doing well with the SEP-1 measure! Great job!**

Thank you for your comments; we will strive to showcase additional presentations.

Question 129: **I often find cases that meet clinical criteria for severe sepsis/septic shock but are not coded as such. How do you handle or manage that?**

The initial patient population for SEP-1 is based on the presence of an ICD-10-CM code from Appendix A Table 4.01 within the specifications manual. If one of these codes is not assigned to a patient's medical record that patient will not be in the measure population.

Question 130: **How do you respond to physicians that fail to order 30 ml/kg fluids because the patient has end stage renal disease (ESRD) or severe heart failure (HF) and they are concerned about fluid overload?**

The *Crystalloid Fluid Administration* data element does not provide an exclusion from administering crystalloid fluids based on documentation of co-morbidities. Therefore, if the target ordered volume of crystalloid fluids is not administered, Value "2" (No) would be selected for *Crystalloid Fluid Administration*.

Question 131: **Do you consider the ED physician diagnosis as the infection clinical indicator?**

Yes, ED physician/APN/PA documentation of an infection or suspected infection can be used to for *Severe Sepsis Present* criteria A. However, it is not the only source. Please refer to the specifications manual for more information.