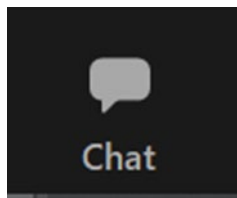


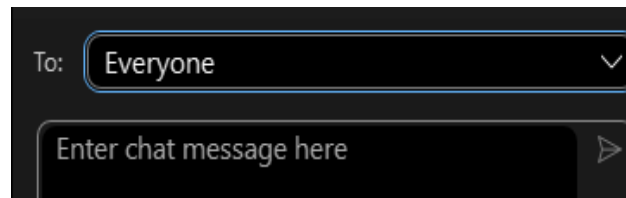
We Will Get Started Shortly

- Lines have been muted upon entry to reduce background noise
- We encourage you to ask questions for the presenter(s) throughout the event using the **Chat Box** feature
- Please enter your name, role, organization and State into Chat Box

Open Chat



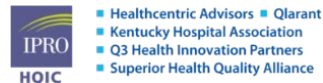
Scroll Down & Select To **Everyone**



Transitions in Care: Preventing Sepsis Readmissions

April 27, 2023

Please Note: This LAN is being recorded.

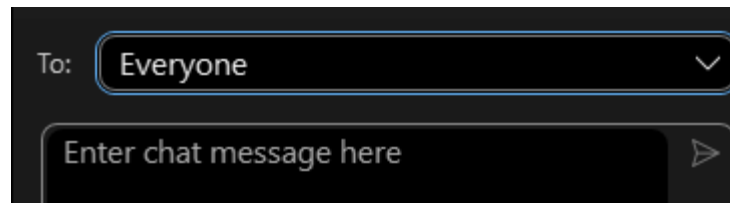


How to Use & Send a Message in Chat Box

Open **Chat** Panel



Scroll down and select **'Everyone'**



Agenda

- Welcome & Introductions
- National Sepsis-related Readmissions Data & Trends
- Care Coordination & Partnerships Across the Continuum in Preventing Sepsis-related Readmissions
- Sepsis Survivor Story
- Q&A
- Tools & Patient Education Resources
- Key Takeaways & Wrap-up



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■ Superior Health Quality Alliance

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
IQUALITY IMPROVEMENT & INNOVATION GROUP

Learning Objectives

- Describe successful care coordination and partnership strategies across the care continuum to prevent sepsis-related hospital readmissions.
- Explore promising practices for overcoming challenges that affect care coordination and handoffs to the next level of care.
- Learn how to engage patients and families as partners and integrate their health-related social needs into the discharge planning process to improve patient outcomes.
- Hear about a sepsis survivor story.



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Featured Speakers



Amanda Karrels, BS RN CPHQ
Clinical Quality Coordinator
Monument Health



Katie Noyes, BSN
Sepsis Coordinator
Monument Health



Jackie Dinterman, M.A., LBSW, ACM
Director of Care Management
Frederick Health



Lisa Bromfield, MSN RN
SNF Nurse Liaison
Frederick Health



Leigh Hunter, LCSW, ACM-CM
Manager of Integrated Care Management
Frederick Health



Karen Holtz, MT (ASCP), MS, CPHQ
HQIC Education Lead
Alliant Health Solutions



Lynne Hall, RN BSN
LSSBB, Master TeamSTEPPS Trainer
Georgia Hospital Association

Facilitator



Lynda Martin, MPA BSN RN CPHQ
Senior Director Patient Safety
Qlarant
IPRO HQIC



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Sepsis Readmissions – National Trends



**SOMEONE
DIES FROM
SEPSIS EVERY
TWO MINUTES**

270,000 people die from sepsis every year in the U.S. – one every two minutes – more than from prostate cancer, breast cancer, and opioid overdose combined.



**SEPSIS COSTS
\$62 BILLION
ANNUALLY**

Sepsis is one of the most costly conditions in the U.S., with costs for acute sepsis hospitalization and skilled nursing estimated to be \$62 billion annually.



**SEPSIS IS THE
LEADING
CAUSE OF
READMISSIONS**

Sepsis is the leading cause of readmission to the hospital, with as many as 19 percent of people originally hospitalized with sepsis re-hospitalized within 30 days and about 40 percent re-hospitalized within 90 days.

<https://www.sepsis.org/references>
https://journals.lww.com/ccmjournal/FullText/2020/03000/Sepsis_Among_Medicare_Beneficiaries3The.4.aspx
<https://jamanetwork.com/journals/jama/article-abstract/2667727?redirect=true>



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Sepsis Readmissions – National Trends



**ADULTS 65+
ARE MORE
LIKELY TO BE
HOSPITALIZED
WITH SEPSIS**

Adults age 65+ are 13 times more likely to be hospitalized with sepsis than adults younger than 65.



**NURSING HOME
RESIDENTS ARE
MORE LIKELY
TO PRESENT
WITH SEPSIS**

Nursing home residents are over six times more likely to present with sepsis in the emergency room than non-nursing home residents.



**AFRICAN AND
NATIVE
AMERICANS
ARE MORE
LIKELY TO BE
READMITTED**

African and Native American patients are more likely to be readmitted following a sepsis hospitalization compared to their white counterparts.

<https://www.sepsis.org/sepsisand/aging>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC34955/>

<https://www.sepsis.org/news/sepsis-alliance-invites-health-sector-colleagues-to-sign-equity-diversity-and-inclusion-pledge/>



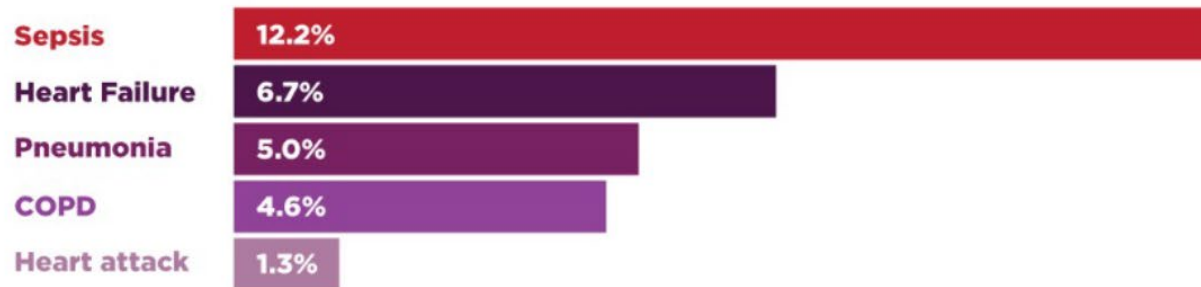
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Sepsis and Readmissions – National Trends

Hospital readmissions and healthcare costs after sepsis

Percentage of hospital readmissions



1 in **3** readmitted
within 90 days

Estimated average cost per readmission



15% of total
readmission-
related costs

From: Proportion and Cost of Unplanned
30-Day Readmissions After Sepsis
Compared With Other Medical Conditions.
JAMA. 2017;317(5):530-531



Partnering to Improve Patient Outcomes and Prevent Sepsis-Related Readmissions

Jackie Dinterman, M.A., LBSW, ACM

Lisa Bromfield, MSN RN

Leigh Hunter, LCSW, ACM-CM

Frederick Health

Our Mission: To positively impact the well-being of every individual in our community



- Frederick Health Hospital (269 licensed beds), Not-for-profit
- Frederick Health Medical Group, Frederick Health Employer Solutions, Frederick Health Home Care, Frederick Health Hospice, Cancer Center
- Frederick County: 40% population growth over the past 25 years resulting in an additional 95,000 people in the health system's service area.



SNF/AL/FHH Collaborative

- Created SNF/AL/FHH collaborative in 1997 to improve communication among post acute providers
- Developed universal FMH/NH/AL transfer form
- Access to Meditech – referral/admission assessment
- Observation status education
- Readmission reduction strategies
- Meetings with nursing leadership to discuss quality of care issues
- NH/AL's take weekend/evening admissions
- **Partnering with CMS QIO Care Transitions Improvement Consultant and NH Improvement Consultant**
- **Successful sepsis readmission reduction initiative**
- Piloting Circle Back program – RN follow up with SNF within 24 hours of dc
- Warm Handoff pilot



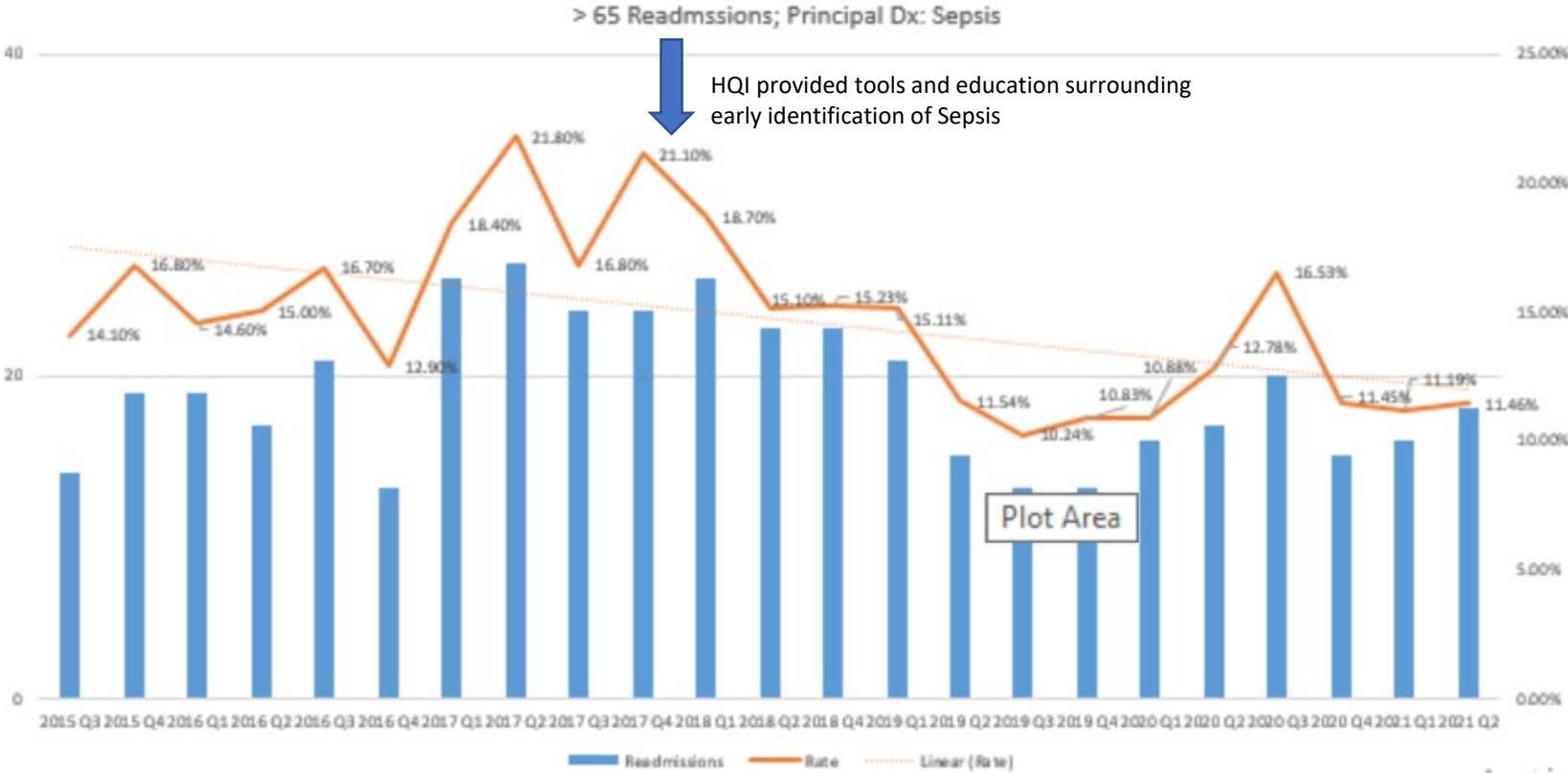
Keys to Success

- Meeting monthly is essential to building relationships
- Build respectful and non-punitive environment – no finger pointing
- Shared goals = shared successes
- Decision makers needed at meetings – Administrators, DON's, Admission Coordinators, Infection Prevention leadership
- Consistently remind mission and goals
- Can learn from all facilities
- Have a hospital champion
- Involvement on hospital committees



Sepsis Data after Start of Project

> 65 Population 30-day Readmissions; Principal Dx: Sepsis



Strategies for Sepsis Identification

- Process change
 - Sepsis risk assessment on admission
 - Ongoing assessment for changes that could mean sepsis – all employees
- Sepsis training & resources to **all** employees at nursing facilities
 - Sepsis pocket cards, posters
 - Sepsis risk assessment evaluation tool
 - SBAR tools and Information, customized to sepsis
 - Resident/family education brochure
- Assessment, feedback on facility infection prevention programs
- Regional sepsis forums to foster dialogue between hospitals, nursing homes for better coordinated sepsis care

If resident has suspected infection AND two or more:

- Temperature >100°F or <96.8°F
- Pulse >100
- SBP <100 mmHg or >40 mmHg from baseline
- Respiratory rate >20/SpO2 <90%
- Altered mental status

Plan for:

- Review advance directive
- Contact the physician
- Contact the family

If transferring resident to hospital:

- Prepare transfer sheet
- Call ambulance
- Call in report to hospital
- Report positive sepsis screen

If resident stays in facility, consider options below that are in agreement with resident's advance directives:

- Labs: CBC w/diff, lactate level (if able)
- UA/UC, blood cultures, as able from 2 sites, not from lines
- Establish IV access for IV 0.9% @ 30ml/kg
- Administer IV, PO or IM antibiotics
- Monitor for worsening in spite of treatment, such as:
 - Urine output <400ml in 24 hours
 - SBP <90 despite IV fluids
 - Altered mental status
- Comfort care:
 - Pain control
 - Analgesic for fever
 - Reposition every 2-3 hrs
 - Oral care every 2 hrs
 - Offer fluids every 2 hrs
 - Keep family informed
 - Adjust care plan as needed
- Consider transferring to another level of care such as palliative care, hospice or hospital

Every hour a resident in septic shock doesn't receive antibiotics, the risk of death increases 7.6%

Call the doctor!

100 seeing sepsis

100 Is their **temperature** **above 100?**

100 Is their **heart rate** **above 100?**

100 Is their **blood pressure** **below 100?**

And does the resident just not look right? Tell the nurse, screen for sepsis and notify the physician immediately.



Then, COVID Happened.....All Focus was on Survival

- Collaborative continued but became virtual webex once per week focusing just on COVID:
 - Frederick County Health Department
 - Nursing and Assisted Living Facilities
 - Frederick Health, FH Supportive and Geriatric Care and FH Hospice
 - DDA residential setting group homes
- TeleSupportive Services implemented quickly to support nursing homes and assisted living facilities



***Coming together is a beginning.
Keeping together is progress.
Working together is success.***

-Henry Ford

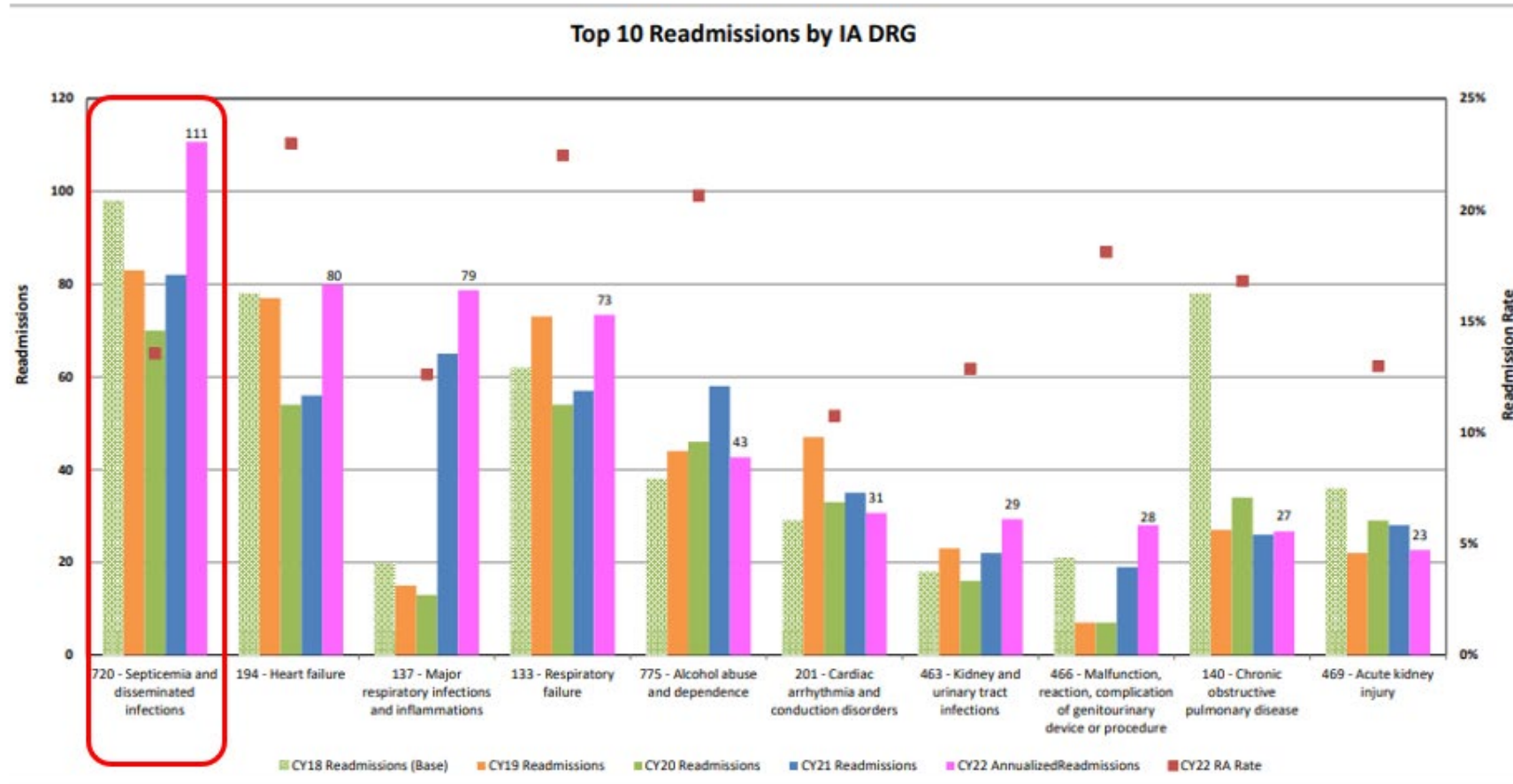
Relationships already built = Shared Goals = Shared Successes

Sepsis Kick Off Initiative – November 2022

- 2 SNF DON's shared successes from the past
- Shared new Sepsis statistics and readmission rates
- Shared past successful tools and new tools
- Recommitted to initiative



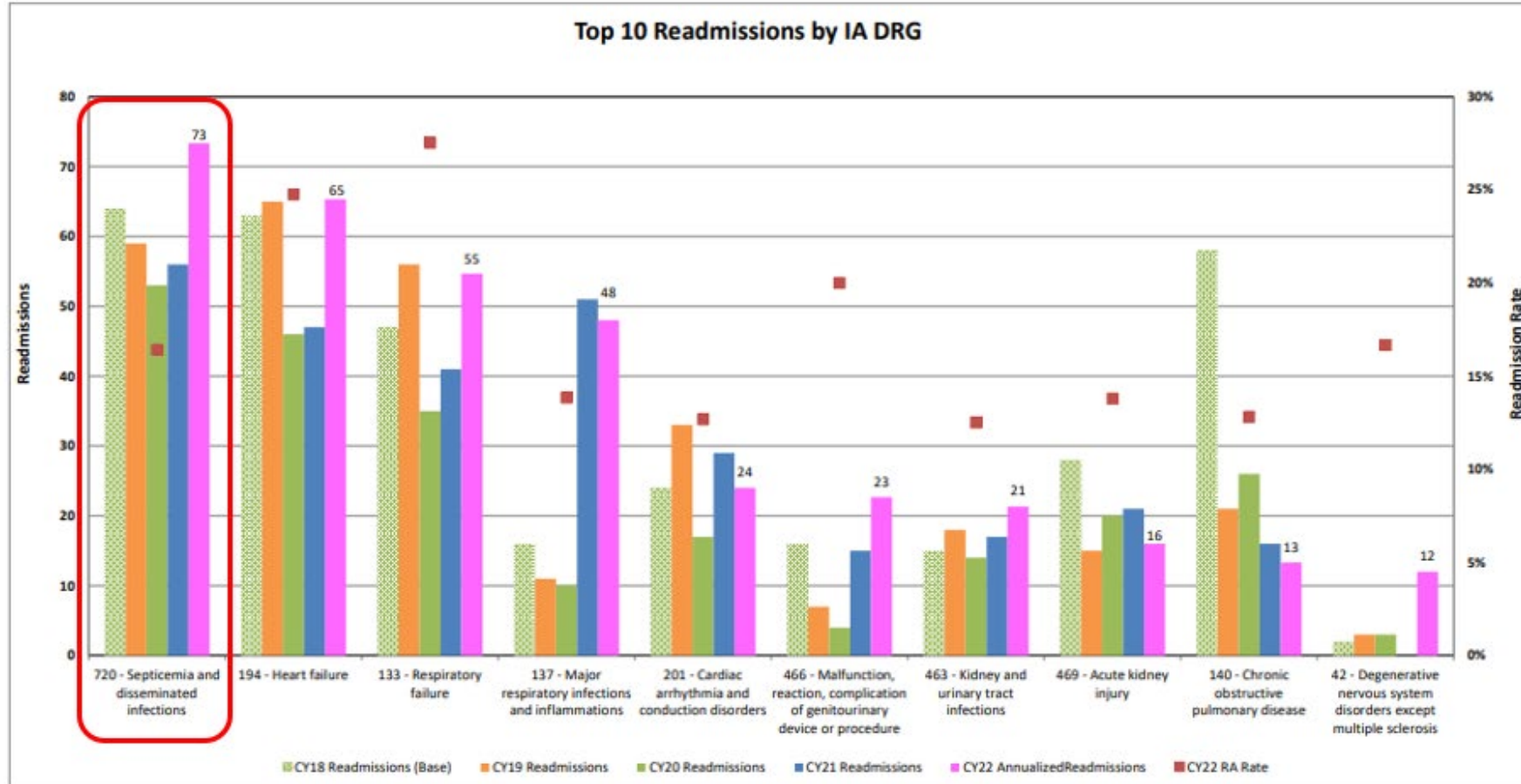
Top 10 IA DRGs



[1]: CY 2020 results exclude COVID-19 discharges.

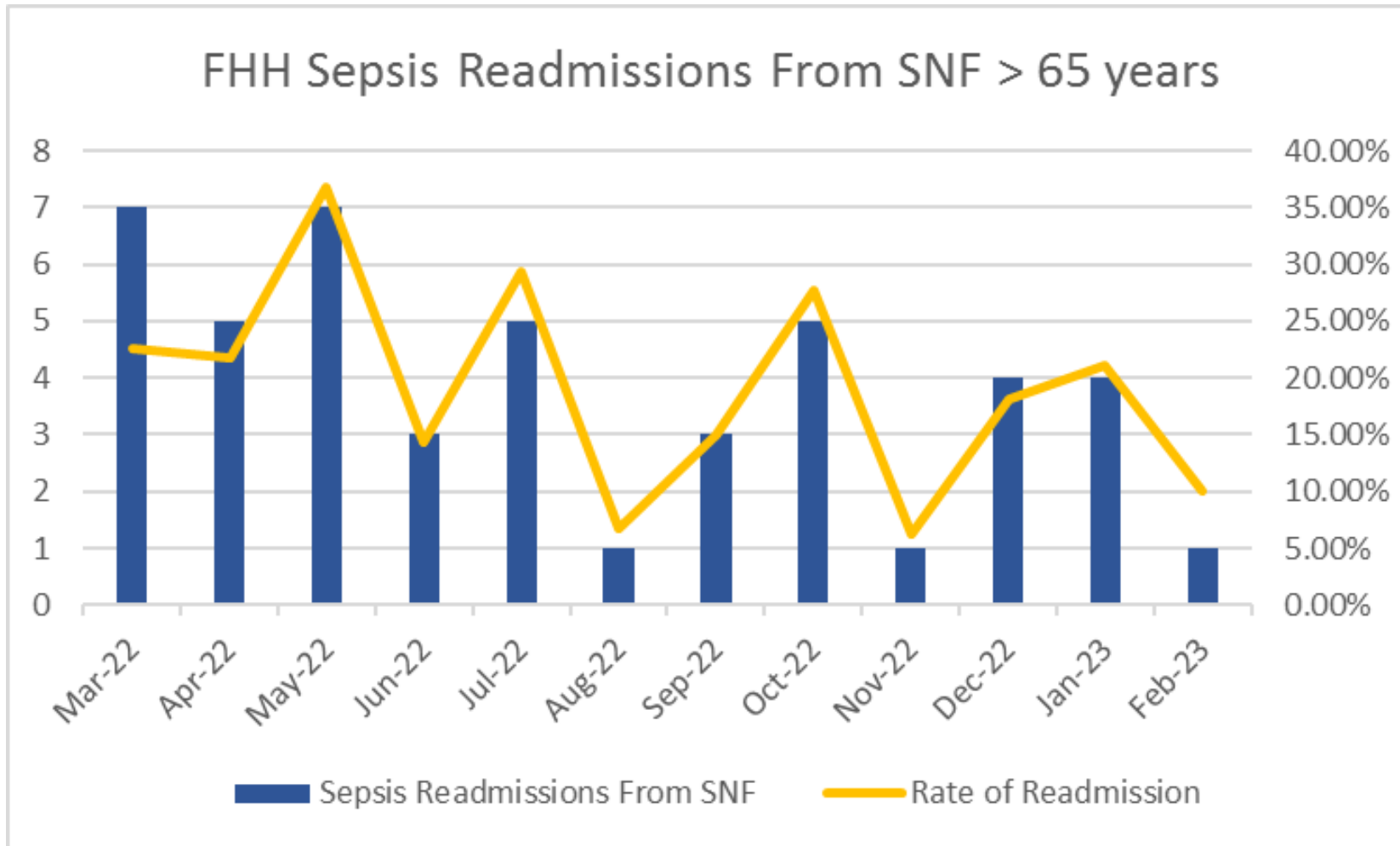
[2]: CY 2021 & CY 2022 results include COVID-19 discharges.

Medicare FFS Top 10 IA DRGs



[1]: CY 2020 results exclude COVID-19 discharges.
 [2]: CY 2021 & CY 2022 results include COVID-19 discharges.

Sepsis Data



Partnering to Prevent Sepsis Harm & Readmissions from Long-Term Care Facilities

Good & Bad Changes = Opportunity

- Need for communication about unknown
 - Fear of transfer
 - COVID changed considerations of transfer
- Chance to improve consideration & communication
 - Real time clinical data prior to transfer
 - What matters to resident / patient
 - Public health concerns
 - Avoid communicating – NO TRANSFERS
- Open Dialogue about transfers to ED

Positive Communication Improves Relationships

- Trust based on mutual assistance and respect
- Ask how you can help them
- Communicate how they can help you (and your mutual patients)
- Find out how Long-Term Care staff feel about calling your staff. How are they treated?

Enhance Collaboration Around Transfers

Recognize problems that affect transfer decisions & outcomes

- Is there communication prior to a transfer?
- Can you discuss transfers at some point? Via Roundtable or a call when patient is discharged.
 - How was discharge information? (hospital accountability)
 - Was the transfer necessary and/or timely? (SNF accountability)
- Know the abilities of different facilities ahead of time
 - Who handles what / does what
- Completed MOLST* (POLST) & Advance Directive - How are updates shared?
- How LTC staffing affects transfers
 - Credentials, shift, staffing levels & off-site or on-site
- How reimbursement affects transfers
- Are your staff tuned in to these questions?

*Medical Orders for Life-Sustaining Treatment

What about Sepsis?

- You want Long Term Care staff to surveil, recognize, then treat, or transfer as appropriate.
- Can they communicate with you to achieve this?
- Tele-Supportive Services calls were a way to communicate and to model calm assessment
 - Used a transcript to help NPs address crisis / panic
 - Does LTC do training around ACP / MOLST and death with staff so they do not panic
- Recognize possible sepsis and begin protocol
 - As able

Are Staff at Facilities Looking for Sepsis?

- We had an experience pre-pandemic with increased sepsis surveillance
 - Teaching done with 2 LTCs
 - Tools initiated to draw attention to anyone with possible sepsis or risk factors
- Survey LTCs
 - Would they be interested in receiving help with education?
 - Can they start IVs, get and hang antibiotics quickly, etc.?
 - Barriers they see to engaging in this initiative
- Share benefits to engaging in this initiative
 - Are benefits all yours?

True Collaboration is a Two-Way Street

- Be open to limitations & worries related to sepsis
- Ask them, where can YOU improve?
 - For us - discharge information/calling report
 - Imperative to ask & follow up
 - Follow up includes – still working on it, haven't forgotten
 - Do you have a liaison or relationship with DONs?
 - Do you have a geriatrics department/specialist/ outreach? Include them!
- Remember to consider benefit for facilities
 - When will the CMS dings for readmissions be felt?
 - How does that cost compare to change?

Strategies for Education

- Arrange to educate in person or virtually
- Teach to your audience
 - Scope of practice / education level
 - Who will do which part of surveillance?
- Do they have time or bandwidth?
 - If you provide education, consider recording
 - High turnover
 - Sustainability
- Need champions
 - Among group being taught, not just supervisors
- Use data to focus education needs – or shared resources...

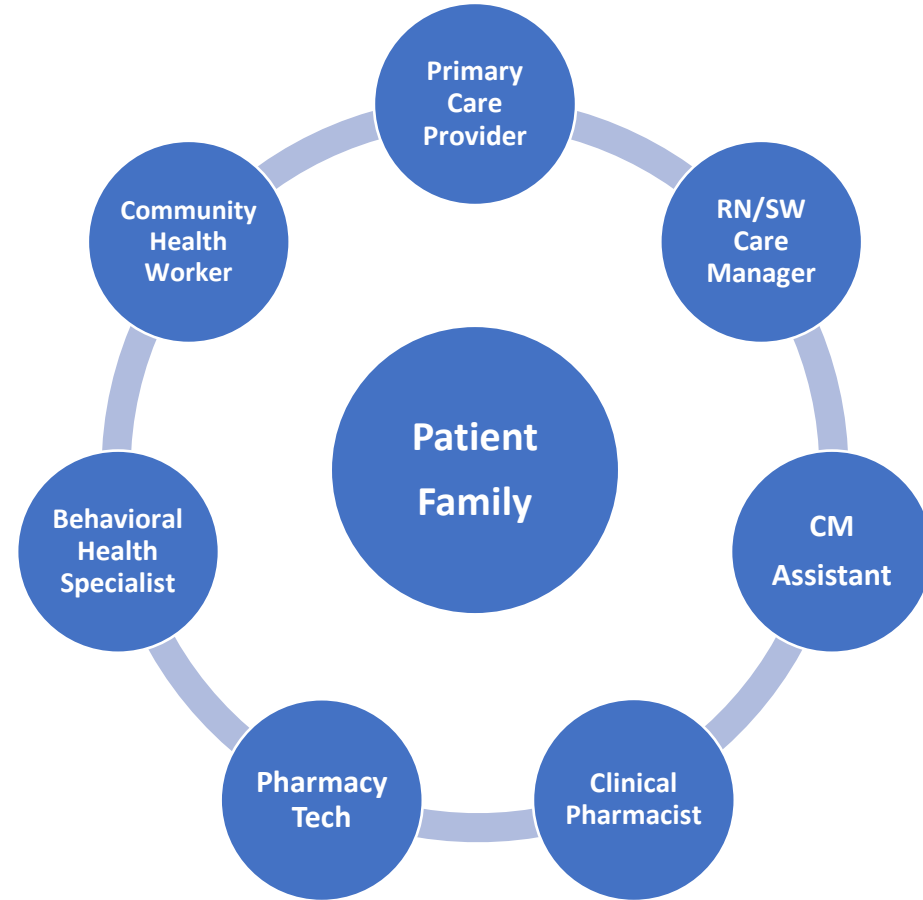
Data Driven Education & Collaboration

- Some DATA to Collect
 - How many folks sent from LTC to R/O sepsis
 - How many of those folks were admitted
 - Which facilities they came from
 - # of sepsis admissions sent for something else?
 - Presenting concern for folks not sent for sepsis but admitted for sepsis?
 - Outcomes by site
 - Are some sending sicker folks – some catching earlier?
- Site specific data should be shared with admin of site
 - To measure needed change and note positive change
 - And to get buy-in for further and specific education
 - Hope based on the success of others!

Integrated Care Management

- Who are we?
 - A multidisciplinary care management team supporting primary care practices
- Who do we support?
 - Frederick Integrated Healthcare Network (FIHN) clinically integrated network
 - 16 primary care practices with Frederick Health Medical Group and the community
 - 4 pediatric practices

Integrated Care Management Team



Engagement

- Transitions of Care
- Provider/Care Team Referrals
- Risk Stratification Tools
- Community Partner Referrals

Interventions

- Transportation assistance
- Information & Referral
- Advanced Care Planning
- Caregiver Support
- Self-Management Education
- Goal Setting
- Home visits
- Appointment Scheduling
- SoDH assessment
- Long term care planning
- Comprehensive Medication Management
- Behavioral Health Support

Community Partners

- Agencies (Dept of Aging)
- DSS
- Private Duty
- HHC
- FH Ambulatory CM programs
- Food Security agencies
- Transportation services
- SNF/ALF
- CDSMP/DPP
- Pharmacies

Collaboration Opportunities with SNF/AL

- May receive contact from CM team for updates on discharge plans
- CM team can provide important information on home environment/social needs/barriers to care
- Clinical pharmacist communication
- Contact within primary care practice to help facilitate post-discharge appointments
- Team will outreach to patient following a SNF discharge and intervene as needed
- Referrals for placements from community (skilled, respite, LTC)

Sepsis Assessment

- Transitions of Care assessments are standardized across ambulatory care management teams
- Allows for screening for complications after discharge related to CHF/COPD/Sepsis
- Sepsis Assessment includes:
 - Heart rate/breathing
 - Temperature
 - Skin/Nails
 - Energy
 - Thinking

Choosing the Right Level of Care in a Medical Emergency



Everyone knows that a primary care doctor is the best place to go when you are sick or in pain. By seeing your primary care physician on a regular basis, they will have your complete health history and an understanding of any underlying conditions you may have.

Sometimes you become sick or injured when the doctor's office is closed, and sometimes you need more urgent medical attention than your doctor can provide. This handout helps to explain **where to seek the best care in your time of need.**

Primary Care Call to make an appointment with your primary care provider if you have symptoms of a regular illness or need a regular check-up.

- Treatment of illness, including:
 - Colds and coughs
 - Sore throat
 - Flu and flu-like symptoms
 - Ear infections
 - Urinary tract infections
 - Minor aches and pains
 - Allergies
- Management of chronic conditions, such as:
 - Diabetes
 - Heart Disease
 - COPD
- General medical advice
 - Annual Well Exams
 - Immunizations
 - Respiratory problems

If you believe a life is in jeopardy, always call 911!

Urgent Care is an option if you have a minor illness or injury, your primary care provider is not available, and your problem cannot wait.

- Treatment of illness, including:
 - Colds, coughs, and upper respiratory infections;
 - Sore throat;
 - Flu and flu-like symptoms;
 - Ear infections/Earache;
 - Suspected urinary tract infection;
 - Sexually Transmitted Illness;
 - Fever **If having seizures, go to the Emergency Department**
- Upset stomach
- Nausea or vomiting
- Adult IV hydration
- Skin rashes and infections
- Abscesses
- Sprains or suspected minor broken bones
- Musculoskeletal injuries
- Back pain or joint pain
- Toothache (if dentist is not available)
- Allergies
- Animal or insect bite
- Eye irritation and redness
- Minor cut/abrasion and sutures/stitching
- Minor burn
- Frequent, bloody, or painful urination
- Motor Vehicle Collision exams
- Workman's Comp exams
- Sports/DOT physicals
- Travel vaccines
- Laboratory and blood work
- X-Rays

(over) 1

Choosing the Right Level of Care in a Medical Emergency cont.

The Emergency Department (ED) is open 24 hours a day, 7 days a week. You should seek care at the Emergency Department without delay if you have a serious or a life-threatening illness or injury.

- Chest pain or other heart attacks symptoms, such as:
 - Pressure, fullness, squeezing/pain in the center of your chest
 - Tightness/burning/aching under the breastbone
 - Chest pain with lightheadedness
- Signs of a stroke, such as:
 - Sudden weakness or numbness of the face/arm/leg on one side of the body
 - Sudden dimness or loss of vision
 - Loss of speech or trouble talking
 - Sudden severe headaches with no cause
- Head injury or eye injury
- Sudden and severe headache or loss of vision
- Heavy bleeding that won't stop
- Dislocated joints
- Severe abdominal pain
- Deep cuts or severe burns
- High fever
- Severe asthma attack
- Loss of consciousness
- Severe or worsening reaction to an insect bite, sting, or medications
- Constant, severe/persistent vomiting
- Coughing up or vomiting blood
- Poisoning **Call Poison Control at 1-800-222-1222 and ask for immediate home treatment advice**
- Domestic violence or rape
- Feelings of suicide

If you believe a life is in jeopardy, always call 911!



Improving Sepsis Care In A Critical Access Hospital

Presented by
Amanda Karrels BS, RN, CPHQ
Katie Noyes, BSN



VISION

It starts with heart.

Our vision is to be one team, to listen, to be inclusive,
and to show we care.

To do the right thing. Every time.

VALUES

Trust
Respect
Compassion
Community
Excellence

PRIORITIES

Deliver high-quality care
Provide a caring experience
Be a great place to work
Impact our communities
Be here for generations to come

MISSION

Make a difference. Every day.

Why Sepsis?

Increased Compliance
With Early Sepsis
Management
Preventing
Sepsis-related
Readmissions
In A Critical Access
Hospital



www.sepsisawarenessmonth.org (Link)



Centers for Medicare and Medicaid Services (CMS) SEP-1

Treatment Bundle

Within 3 hours:

- Initial Lactic Acid
- Blood cultures drawn prior to antibiotics
- Start broad-spectrum antibiotics
- 30 ml/kg fluid bolus
-Any initial LA > 4 or initial hypotension

Within 6 hours:

- Repeat Lactic acid
Reflex order will only place repeat when >2
- Vasopressors
- Provider Documentation of Repeat Volume and Tissue Perfusion Assessment

Severe Sepsis 3-Hour Bundle SEV_SEP_3

Percentage of patients who received an intravenous antibiotic, had blood cultures drawn prior to antibiotics, and had a lactate level drawn, all within three hours of severe sepsis presentation.

Numerator: (Patients who)

- Met all requirements for the broad spectrum or other antibiotic administration data elements and calculations, and who were not excluded for broad spectrum antibiotic timing being less than -1440 minutes, AND
- Met all requirements for the blood culture collection data elements and calculations, AND
- Met all requirements for the initial lactate level collection data elements and calculations.

Denominator: (Patients who)

- Are age 18 years and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis, or Septic Shock and not equal to U07.1 (COVID-19), with a length of stay less than or equal to 120 days, AND
- Met *Severe Sepsis Present* data element criteria, AND
- Were not transferred from another hospital, were not in a clinical trial, did not have an administrative contraindication to care for severe sepsis, did not have a directive for comfort care or palliative care for severe sepsis, and were not discharged more than six hours after severe sepsis presentation.

Severe Sepsis 6-Hour Bundle SEV_SEP_6

Percentage of patients who had an elevated *Initial Lactate Level Result* (> 2 millimoles per litre [mmol/L]), and had a repeat lactate drawn within six hours of severe sepsis presentation.

Numerator:

(Patients who)

- Met all requirements for the repeat lactate level collection data elements and calculations.

Denominator:

(Patients who)

- Met all requirements for the Severe Sepsis 3-hour bundle, and had an elevated *Initial Lactate Level Result* (> 2 mmol/L).

Septic Shock 3-Hour Bundle SEP_SH_3

Percentage of patients who had *Initial Hypotension* or septic shock, and 30 mL/kg of crystalloid fluids were started within three hours of septic shock or initial hypotension presentation.

Numerator:

(Patients who)

- Met all requirements for the *Initial Hypotension* (if present), septic shock (if present) data elements and calculations, AND
- Met all requirements for the crystalloid fluid administration data elements and calculations.

Denominator:

(Patients who)

- Met all requirements for the Severe Sepsis 3-hour bundle and Severe Sepsis 6-hour bundle (if eligible), AND
- Met criteria for *Initial Hypotension* (if present) or *Septic Shock Present* (if present) data elements, AND
- If septic shock was present, did not have an administrative contraindication to care for septic shock, did not have a directive for comfort care or palliative care for septic shock, and were not discharged more than six hours after septic shock presentation.

Septic Shock 6-Hour Bundle SEP_SH_6

Percentage of patients who received a vasopressor, if persistent hypotension was present, and who had a repeat status and tissue perfusion assessment completed within six hours of persistent hypotension or septic shock presentation.

Numerator:

(Patients who)

- If *Persistent Hypotension* was present, met all requirements for the vasopressor administration data elements and calculations, AND met all requirements for the repeat volume status and tissue perfusion assessment data elements and calculations, OR
- If persistent hypotension was not present but septic shock was present, met all requirements for the repeat volume status and tissue perfusion assessment data elements and calculations.

Denominator:

(Patients who)

- Met all requirements for the Septic Shock 6-hour bundle for which they were eligible, AND
- Met criteria for *Persistent Hypotension* OR an *Initial Lactate Level Result* greater than or equal to 4 mmol/L.



Severe Sepsis and Septic Shock
Severe Sepsis and Septic Shock Measure

Severe Sepsis and Septic Shock 3-Hour Management Bundle Compliance (NQF 0500)
Self-Reported
Higher is Better



	Jan '20	Feb '20	Mar '20	Apr '20	May '20	Jun '20	Jul '20	Aug '20	Sep '20	*Oct '20	Nov '20	Dec '20	Jan '21	Feb '21	Mar '21	Apr '21	May '21
Facility	0.00	0.00	100.00		33.33	33.33	0.00			33.33			50.00		0.00	100.00	50.00
Avg HQIC	67.68	72.11	69.76	69.29	68.54	67.65	77.60	74.66	74.13	68.08	39.10	67.66	65.27	66.60	67.77	50.41	66.87
Num/Den	0/2	0/1	2/2	0/0	1/3	1/3	0/1	0/0	0/0	1/3	0/0	0/0	1/2	0/0	0/2	1/1	1/2

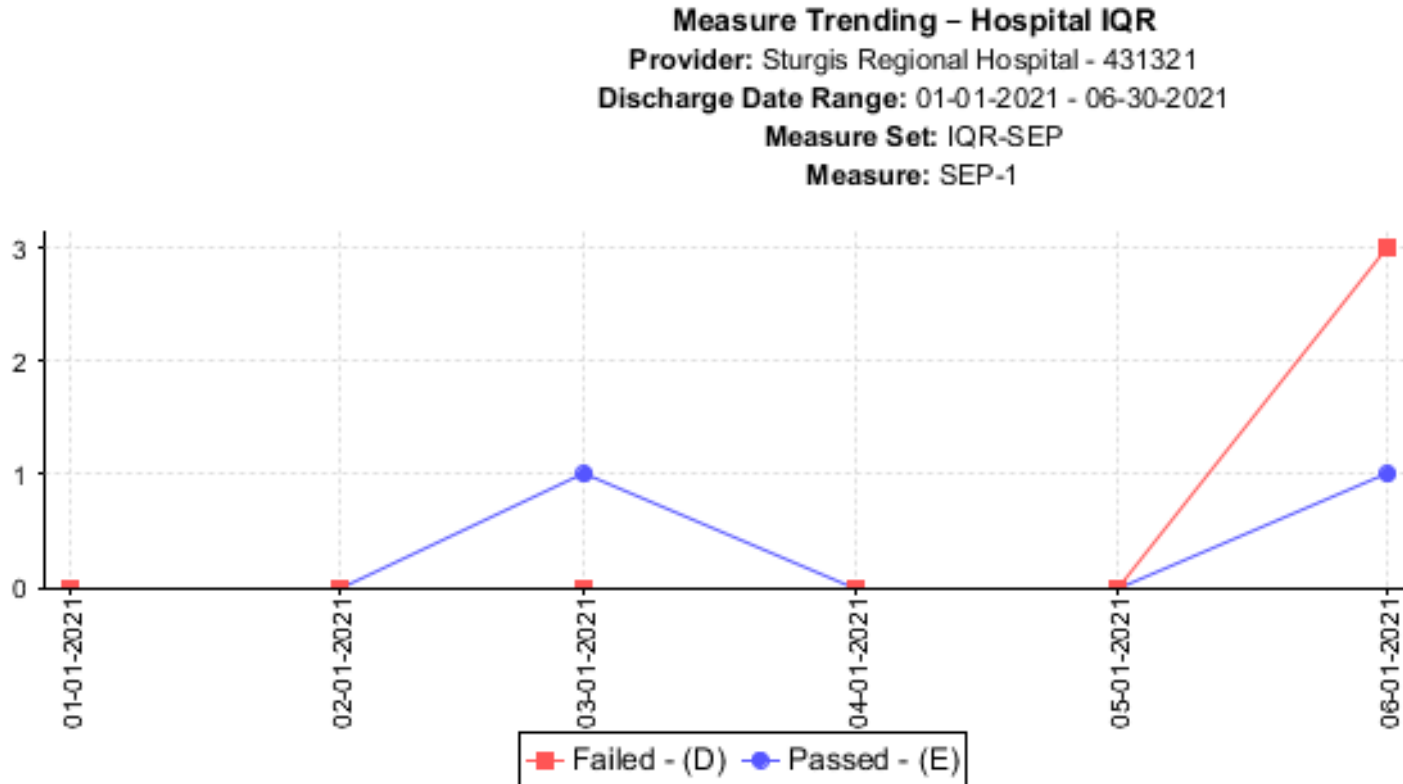
	Jun '21
Facility	75.00
Avg HQIC	70.27
Num/Den	3/4

Month	Intervention
*Oct '20	Two physicians have joined the system Sepsis PI team.

CMS Reporting – All Sepsis Measures

Report Run Date: 03-02-2022

Page: 1 of 1



Note: Low numbers and inconsistent performance

Opportunity to Improve

- Transferred > Admitted
- What data was not being captured?
- Why is our data inconsistent



Excellence
Just Ahead

Goal

Provide consistent and high-quality care to patients with sepsis including both those who are admitted to the Sturgis Hospital and those who are transferred to a higher level of care.



MONUMENT
HEALTH

2140 Junction Avenue

STURGIS

Hospital & Clinics

+ Emergen



Action

- Continued measurement and participation in HQIC database as well as CMS reporting for patients admitted to the Sturgis Hospital
- Added measurement of sepsis charts for patients transferred to higher levels of care for both the 3- and 6-hour bundles
- Physician and nurse peer feedback on opportunities identified in chart reviews, including those chart that are not reported i.e. transferred patients
- Targeted education during department meetings with emphasis on documentation and the resources available
- Physician and nurse peer feedback on great care
- Continued participation and collaboration with system and Hills' market sepsis team
- Regular reporting of data to medical and nursing staff
- Inclusion of Sturgis Urgent Care Services
- Creation of reference sheets for Emergency Department and for Urgent Care Services

Provider Documentation Requirements SEPSIS QUALITY DOCUMENTATION

MH Severe Sepsis and Septic Shock Quality Checklist | HPI | ROS | Physical Exam | Procedures | MDM

Concern for infection/sepsis:

Concern for SEVERE sepsis:

Severe Sepsis
SIRS (2+/4) AND any organ dysfunction (any 1 of the following: lactate >2, hypotension - SBP <90 or MAP <65, Cr >2, Bili >2, Plt <100,000, INR >1.5 (not on AC), or MC - intubation, CPAPA, or BiPAP)

Lactate

Lactate < 2- No repeat required

Lactate > 2- Repeat ordered within 6h

Blood Cultures

Blood culture(s) obtained prior to antibiotics

Unsuccessful attempts to collect blood cultures. Given severity of infection and risk for deterioration from rapidly advancing infection, antibiotics were given prior to blood culture collection.

Please document "Time of noted delay if blood Cx not prior to Abx"

Antibiotics

Less than 3 hours

Greater than 3 hours

IVFs

SBP < 90 mmHg and/or MAP < 65 mmHg and/or Lactate >4

Concerned 30 cc/kg bolus would be harmful for the patient

Not indicated (no hypotension and/or lactate <4)

Septic Shock

Provider documentation of Septic Shock AND/OR Lactate greater than equal to 4 AND/OR Persistent HypoTN after IVF bolus

Volume Status & Tissue Perfusion Assessment

I have reassessed patient's hemodynamic status & tissue perfusion after target bolus given

Please document "Time of exam"

IVFs

SBP < 90 mmHg and/or MAP < 65 mmHg and/or Lactate >4

Concerned 30 cc/kg bolus would be harmful for the patient

Not indicated (no hypotension and/or lactate <4)

Contraindicated due to:

Concern for fluid overload

Heart failure

Renal failure

Blood pressure responded to lesser volume of fluid

Volume instead of 30 cc/kg

250 ml crystalloid fluid bolus

500 ml crystalloid fluid bolus

1000 ml crystalloid fluid bolus

Results

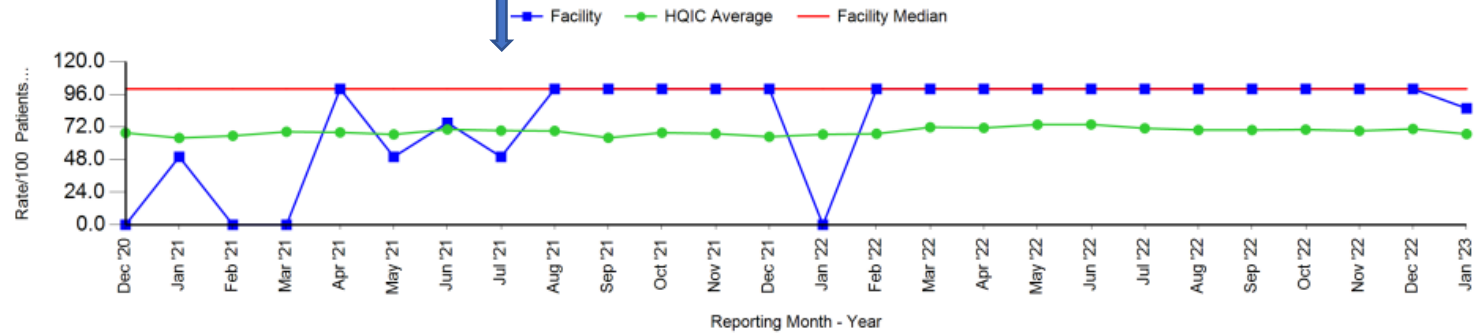
PI project started July 2021

COMPASS | DATA PORTAL

Compass Hospital Quality Improvement Contractors (HQIC) Run Charts
Monument Health Sturgis Hospital

Severe Sepsis and Septic Shock
Severe Sepsis and Septic Shock Measure

Severe Sepsis and Septic Shock 3-Hour Management Bundle Compliance (NQF 0500)
Self-Reported
Higher is Better



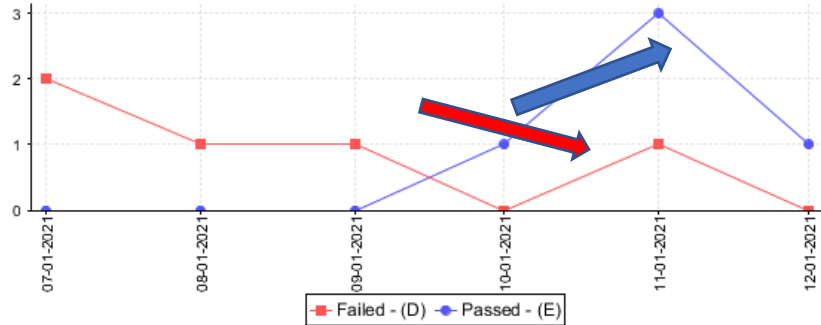
	Dec '20	Jan '21	Feb '21	Mar '21	Apr '21	May '21	Jun '21	Jul '21	Aug '21	Sep '21	Oct '21	Nov '21	Dec '21	Jan '22	Feb '22	Mar '22	Apr '22
Facility	0.00	50.00	0.00	0.00	100.00	50.00	75.00	50.00	100.00	100.00	100.00	100.00	100.00	0.00	100.00	100.00	100.00
Avg HQIC	67.66	63.89	65.46	68.46	67.99	66.52	70.18	69.29	69.08	64.02	67.76	67.05	64.78	66.52	66.98	71.75	71.30
Num/Den	0/0	1/2	0/0	0/2	1/1	1/2	3/4	1/2	1/1	2/2	2/2	4/4	1/1	0/0	2/2	1/1	1/1
	May '22	Jun '22	Jul '22	Aug '22	Sep '22	Oct '22	Nov '22	Dec '22	Jan '23								
Facility	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	85.71								
Avg HQIC	73.72	73.80	71.01	69.75	69.73	70.06	69.10	70.53	66.79								
Num/Den	1/1	4/4	4/4	5/5	5/5	1/1	2/2	3/3	6/7								

Results

CMS Reporting – All Sepsis Measures

Report Run Date: 03-02-2022

Measure Trending – Hospital IQR
 Provider: Sturgis Regional Hospital - 431321
 Discharge Date Range: 07-01-2021 - 12-31-2021
 Measure Set: IQR-SEP
 Measure: SEP-1



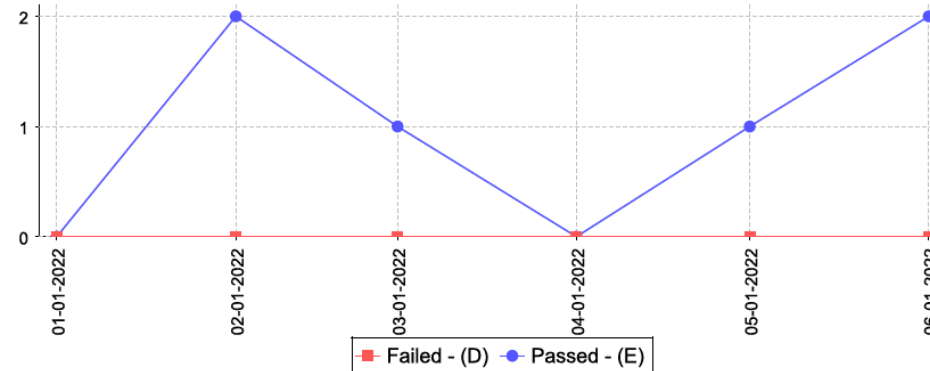
Page: 1 of 1

Note: Increase in pass rate and decrease in fail rate

Note: Zero admitted Severe Sepsis/Septic Shock patients in January and April 2022

Report Run Date: 02-06-2023

Measure Trending – Hospital IQR
 Provider: Sturgis Regional Hospital - 431321
 Discharge Date Range: 01-01-2022 - 06-30-2022
 Measure Set: IQR-SEP
 Measure: SEP-1

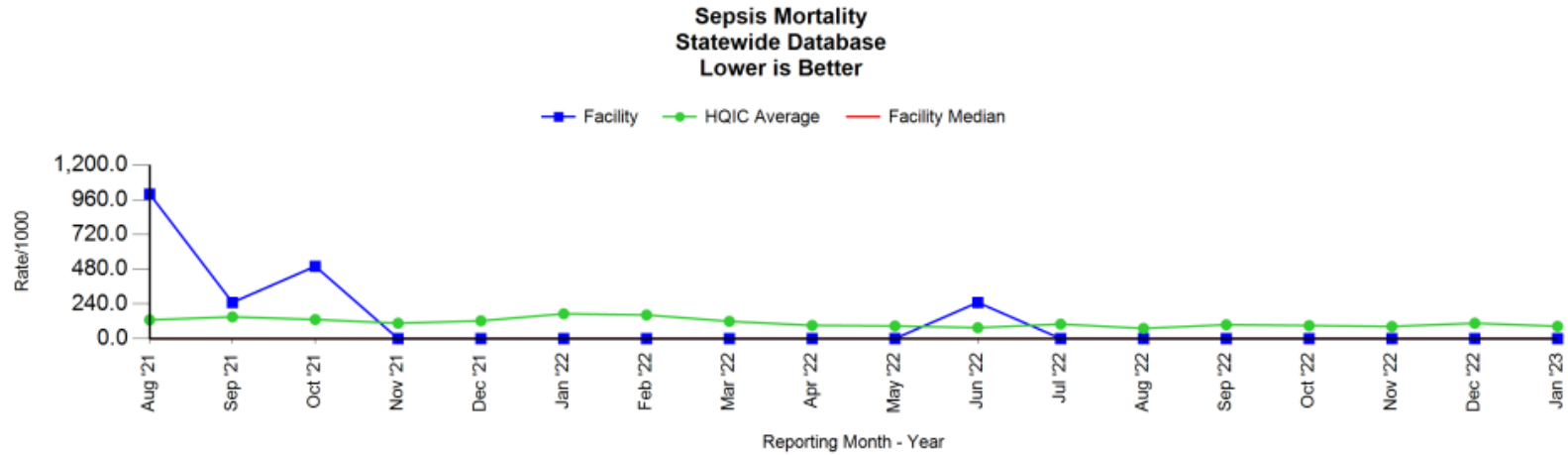


Results



Compass Hospital Quality Improvement Contractors (HQIC) Run Charts Monument Health Sturgis Hospital

Severe Sepsis and Septic Shock *Severe Sepsis and Septic Shock Measure*



	Aug '21	Sep '21	Oct '21	Nov '21	Dec '21	Jan '22	Feb '22	Mar '22	Apr '22	May '22	Jun '22	Jul '22	Aug '22	Sep '22	Oct '22	Nov '22	Dec '22	
Facility	1,000.00	250.00	500.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	250.00	0.00	0.00	0.00	0.00	0.00	0.00	
Avg HQIC	129.30	150.00	131.91	106.35	122.69	171.80	163.28	119.36	91.25	87.22	75.44	100.00	70.41	95.68	90.19	84.04	106.29	
Num/Den	1/1	1/4	1/2	0/5	0/2	0/1	0/2	0/1	0/1	0/1	1/4	0/4	0/0	0/2	0/4	0/0	0/7	
	Jan '23																	
Facility	0.00																	
Avg HQIC	84.99																	
Num/Den	0/6																	



Impacts

- Through collaboration, data monitoring, and a feedback loop, strong improvements in quality can be demonstrated
- Supports our organizational priority to deliver high quality care
- Improved patient outcomes
 - Patients transferred to higher levels of care
 - Decreasing sepsis mortality
 - Decreasing Sepsis related readmissions

Total Hospital Readmissions

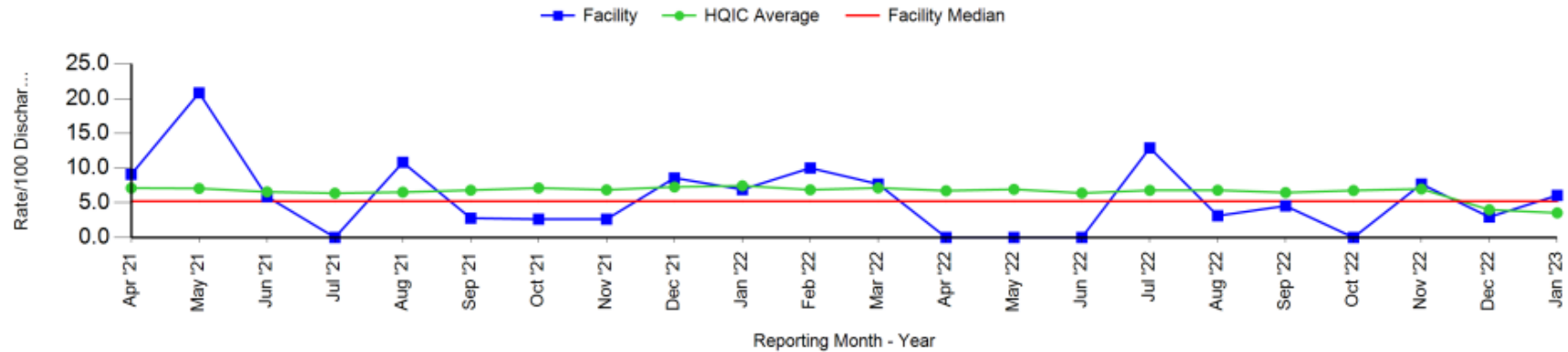


Compass Hospital Quality Improvement Contractors (HQIC) Run Charts Monument Health Sturgis Hospital

Readmissions

Readmissions Measure

Unplanned All-Cause, 30-Day Readmissions Same Hospital
Statewide Database
Lower is Better



	Apr '21	May '21	Jun '21	Jul '21	Aug '21	Sep '21	Oct '21	Nov '21	Dec '21	Jan '22	Feb '22	Mar '22	Apr '22	May '22	Jun '22	Jul '22	Aug '22
Facility	9.09	20.83	5.88	0.00	10.81	2.78	2.63	2.63	8.57	6.90	10.00	7.69	0.00	0.00	0.00	12.90	3.13
Avg HQIC	7.11	7.06	6.57	6.37	6.53	6.81	7.13	6.86	7.28	7.44	6.87	7.14	6.73	6.93	6.39	6.79	6.81
Num/Den	2/22	5/24	2/34	0/27	4/37	1/36	1/38	1/38	3/35	2/29	2/20	2/26	0/22	0/24	0/26	4/31	1/32

	Sep '22	Oct '22	Nov '22	Dec '22	Jan '23
Facility	4.55	0.00	7.69	2.94	6.06
Avg HQIC	6.46	6.76	6.99	3.99	3.54
Num/Den	1/22	0/23	3/39	1/34	2/33

Takeaways

- Hospital 30-day readmissions remain a major quality and cost indicator
- Sepsis is a leading cause of hospital readmissions
- Well-defined system processes and compliance for the Severe Sepsis/Septic Shock Early Management Bundle (SEP-1) are crucial to deliver high quality care and reduce readmissions.



Team Members

- Amanda Karrels BS, RN, CPHQ, Quality Coordinator
- Dr. Joy Mueller MD, Family Practice and Emergency Room Physician
- Dr. Chuck Lewis DO, Family Practice and Emergency Room Physician, Community Medical Director
- Dr. Connie Stock MD, Family Practice and Emergency Room Physician
- Dr. Josie Davis MD, Family Practice and Emergency Room Physician
- Dr. Kent Wright MD, Family Practice and Emergency Room Physician
- Sturgis Hospital Emergency Room Nursing Staff, Manager, and Director
- Sturgis Clinic Urgent Care Services Providers, Staff, and Director

References

Society of Critical Care Medicine. *Critical Care Medicine: October 4, 2021. Surviving Sepsis Campaign Guidelines 2021 | SCCM* (Link)

Batalden, P.B. & Davidoff F. (2007). What is quality improvement and how can it transform healthcare. *Quality Safety Health Care*, 16(1):2–3. <https://qualitysafety.bmj.com/content/qhc/16/1/2.full.pdf> (Link)

Community-based Care Transitions Program. Center for Medicare and Medicaid Services Innovation Center. 2019. <https://innovation.cms.gov/initiatives/CCTP/> (Link)

Gaieski DF, et al. Impact of time to antibiotics on survival in patients with severe sepsis or septic shock in whom early goal-directed therapy was initiated in the emergency department. *Crit Care Med*. 2010;38(4):1045–1053.



Questions?

Questions?

VISION

It starts with heart.

Our vision is to be one team, to listen, to be inclusive,
and to show we care.

To do the right thing. Every time.

VALUES

Trust
Respect
Compassion
Community
Excellence

Questions?

Questions?

PRIORITIES

Deliver high-quality care
Provide a caring experience
Be a great place to work
Impact our communities
Be here for generations to come

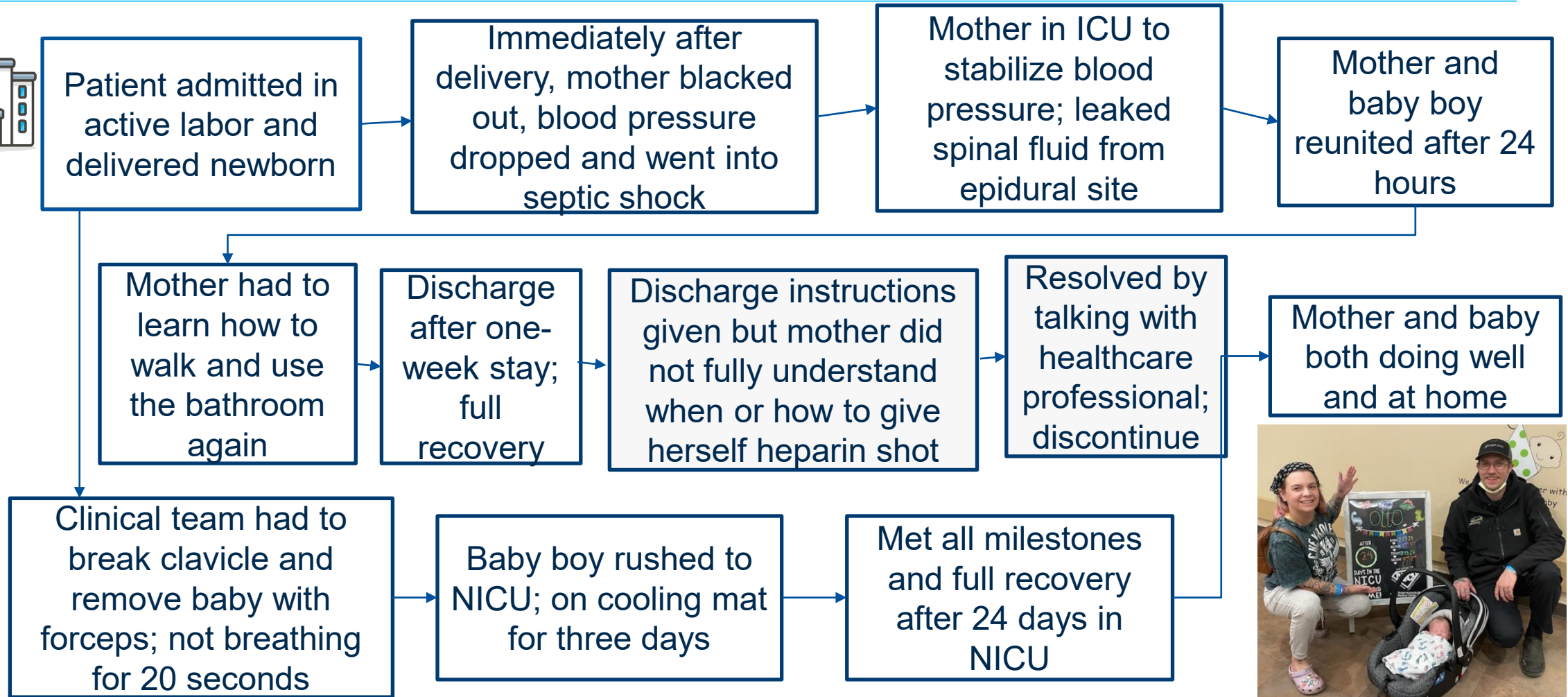
MISSION

Make a difference. Every day.

Sepsis Survivor – Patient Story

Lynne Hall, RN BSN
LSSBB, Master TeamSTEPPS Trainer
Georgia Hospital Association

Patient's Story: Female with pre-eclampsia; uterine infection not found until active labor and went into septic shock



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Interactive Discussion: Panelists & Attendees

- What are some challenges, barriers & successes you have experienced with implementing best practice strategies?
- How can HQICs best support you going forward?
- How are you partnering with patient & families to support safe & equitable transitions in care?
- Have you identified &/or closed any disparities/gaps in care to prevent sepsis-related readmissions?

Please enter your questions or comments into Chat or raise your hand to be unmuted



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Tools & Resources

- **Sepsis Alliance Institute**

- [Sepsis Alliance Institute link](#)

- [Sepsis Alliance Resources link](#)

- [Sepsis Alliance Education link](#)

- **CDC**

- [CDC Sepsis Tools & Resources link](#)

- [CDC Infection Control - Project Firstline link](#)

- [CDC Interactive Infographic](#)

- **Surviving Sepsis Campaign**

- [Surviving Sepsis Campaign link](#)

SEPSIS ALLIANCE SEPSIS INFORMATION GUIDE

LIFE AFTER SEPSIS

THESE ARE THE FACES OF SEPSIS™

Anyone who has an infection is at risk of developing sepsis.

When it comes to sepsis, remember **IT'S ABOUT TIME™**. Watch for:

- T TEMPERATURE** higher or lower than normal
- I INFECTION** may have signs or symptoms of infection
- M MENTAL DECLINE** confused, sleepy, difficult to rouse
- E EXTREMELY ILL** severe pain, discomfort, shortness of breath

CALL 911 OR GO TO A HOSPITAL AND SAY "I'M CONCERNED ABOUT SEPSIS"

Take the **TIME** to learn the signs at [sepsis.org](#).

Hospital Discharge List - Post-Sepsis or Septic Shock

Once you have been told you can go home, you may have questions or concerns. This list is a guideline of some questions you may ask regarding your discharge and suggested actions you may take. Feel free to add your own for a more personalized version. This list is also for caregivers.

Planning	Staff name if applicable	Date accomplished and any notes
Who is my discharge planner? • How do I get hold of them if I have questions?		
Meeting with discharge planner (date and time). • Will there be follow-up meetings? • Who else attended the meeting?		
I have a written copy of my discharge plan.		
Is there someone at the hospital I can contact if I have more questions when I get home?		
What medications will I take at home? • Have they changed since I was admitted to the hospital?		




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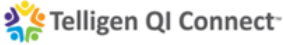
Tools & Resources

HQIC Change Pathway


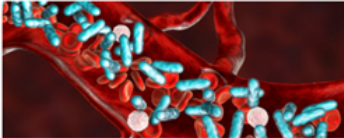

- Compilation of challenges, barriers & best practices for implementation
- Adapt & use to help address your opportunities &/or augment existing interventions
- Links to tools & resources for planning & executing your QI project



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Transitions in Care: Preventing Sepsis-Related Readmissions Change Pathway


Thank you for attending the April 27, 2023 [HQIC Sepsis Webinar!](#) Hospital leaders and front-line staff from across the country attended the event. The small, rural, critical access and large urban hospital voice were amplified through sharing of barriers and best practices alike. Subject matter experts shared their perspectives and their favorite resources. **Now, it is time to act!**

Why Now

Anyone can develop sepsis, a life-threatening, complex and challenging condition to manage. There are significant human and financial costs associated with it. Every year more than 1.7 million adults in

Leading Interventions and Practices

Beginner	Intermediate	Expert
Implement a sepsis screening protocol in your hospital's emergency department to increase early identification. Click here to view an example.	Develop a 1-hr, 3-hr, and/or 6-hr sepsis bundle that includes standing orders (Link) for positive screens.	Stratify data by severity, present on admission, and/or medical vs. surgical to further narrow improvement activities



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Key Takeaways

- **Sepsis is a life-threatening medical emergency**
 - Everyone has a role to play
 - Treating sepsis is costly - significant human & economic impact
 - Use evidence-based practices to reduce variations in care
 - Start sepsis screening now - early detection can save lives
- **Know your data & own your results**
 - Stratify by REAL & SDOH – drill down into root causes
 - Empower teams to design & implement actions to drive improvement
- **Collaborate & coordinate care transitions across the continuum**
 - Form partnerships – engage in active dialogue & listening
 - Helps to prevent sepsis-related harm & readmissions
- **Engage patients & families as partners**
 - Increased communication & education = less confusion
 - Integrate health-related social needs into care & discharge planning to improve outcomes (e.g., health literacy, transportation needs, access to medication, food insecurity etc.)



Wrap-up

- Today's slides, recording & resources shared within 1-2 weeks

Upcoming Events



- **May 11, 2023 | 1 – 2 pm ET**

Partnering with Patients & Families to Prevent All-Cause Harm

[Registration Link](#)

- **June 20, 2023 | 2 – 3 pm ET**

Falls Prevention

Registration forthcoming



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Thank You for Attending Today's Event

We value your input!
Please complete the brief survey after exiting event.



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