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’

Please Share in Chat Your:
- Name
- Role
- Organization
- State
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
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.
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
Sepsis Readmissions – National Trends

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 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 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_Beneficiaries_3_The_4.aspx
https://jamanetwork.com/journals/jama/article-abstract/2667727?redirect=true
Sepsis Readmissions – National Trends

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

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 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/
Sepsis and Readmissions – National Trends

Hospital readmissions and healthcare costs after sepsis

Percentage of hospital readmissions

- Sepsis: 12.2%
- Heart Failure: 6.7%
- Pneumonia: 5.0%
- COPD: 4.6%
- Heart attack: 1.3%

Estimated average cost per readmission

- Sepsis: $10,070
- Pneumonia: $9,533
- Heart attack: $9,424
- Heart Failure: $9,051
- COPD: $8,417

1 in 3 readmitted within 90 days
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

HQI provided tools and education surrounding early identification of 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
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

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

[Image: Bar chart showing top 10 readmissions by IA DRG]

[1]: CY 2020 results exclude COVID-19 discharges.
[2]: CY 2021 & CY 2022 results include COVID-19 discharges.
Top 10 IA DRGs

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

FHH Sepsis Readmissions From SNF > 65 years

- Sepsis Readmissions From SNF
- Rate of Readmission
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?
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

- Community Health Worker
- Behavioral Health Specialist
- Primary Care Provider
- RN/SW Care Manager
- CM Assistant
- Pharmacy Tech
- Clinical Pharmacist
- Patient Family
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: Cold and coughs
  Swine flu
  Flu-like symptoms
  Ear infections
  Lower respiratory infections
  Viral and bacterial infections
- Minor cuts and burns
- Allergies

- Management of chronic conditions, such as: Diabetes
  Hypertension
  Arthritis

- 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: Cold, coughs, and upper respiratory infections;
  Swine flu;
  Flu-like symptoms;
  Ear infections/otitis media;
  Suspected urinary tract infection;
  Sexually transmitted illness;
  Fever, itching, or rash, go to the Emergency Department;
  Unusual stomach pain;
  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 dental is not available)
- Allergies
- Animal or insect bite
- Eye irritation and injuries
- Minor cuts, abrasions, and scratches
- Minor burn
- Frequent, bloody, or painful urination
- Motor Vehicle Collision injuries
- Worker’s Comp injuries
- Sports/DOS physicals
- Travel vaccines
- Laboratory and blood work
- X-Rays

The Emergency Department (ED) is open 24 hours a day, 7 days a week.

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

You should seek care at the Emergency Department without delay if you have a serious or a life-threatening illness or injury:

- 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
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
- 30 ml/kg fluid bolus
  - Any initial LA > 4 or Initial hypotension

---

### 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, within three hours of severe sepsis presentation.

**Numerator:**
- Met all requirements for the broad-spectrum antibiotic administration data elements and calculations, 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:**
- 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.

---

### Sepsis 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 sepsis shock or initial hypotension presentation.

**Numerator:**
- 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:**
- 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.

---

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

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

Severe Sepsis and Septic Shock 3-Hour Management Bundle Compliance (NQF 0500)

Self-Reported
Higher is Better

Facility  HQIC Average  Trend  Facility Median

<table>
<thead>
<tr>
<th></th>
<th>Jan '20</th>
<th>Feb '20</th>
<th>Mar '20</th>
<th>Apr '20</th>
<th>May '20</th>
<th>Jun '20</th>
<th>Jul '20</th>
<th>Aug '20</th>
<th>Sep '20</th>
<th>Oct '20</th>
<th>Nov '20</th>
<th>Dec '20</th>
<th>Jan '21</th>
<th>Feb '21</th>
<th>Mar '21</th>
<th>Apr '21</th>
<th>May '21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>0.00</td>
<td>0.00</td>
<td>100.00</td>
<td>33.33</td>
<td>33.33</td>
<td>0.00</td>
<td>33.33</td>
<td>0.00</td>
<td>33.33</td>
<td>33.33</td>
<td>50.00</td>
<td>0.00</td>
<td>100.00</td>
<td>50.00</td>
<td>0.00</td>
<td>100.00</td>
<td>50.00</td>
</tr>
<tr>
<td>Avg HQIC</td>
<td>67.68</td>
<td>72.11</td>
<td>69.76</td>
<td>69.29</td>
<td>66.54</td>
<td>67.65</td>
<td>77.60</td>
<td>74.66</td>
<td>74.13</td>
<td>68.08</td>
<td>67.66</td>
<td>65.27</td>
<td>66.60</td>
<td>67.77</td>
<td>50.41</td>
<td>66.87</td>
<td></td>
</tr>
<tr>
<td>Nut/Den</td>
<td>0/2</td>
<td>0/1</td>
<td>2/2</td>
<td>0/0</td>
<td>1/3</td>
<td>1/3</td>
<td>0/1</td>
<td>0/0</td>
<td>1/0</td>
<td>0/0</td>
<td>1/0</td>
<td>0/0</td>
<td>0/2</td>
<td>1/1</td>
<td>1/0</td>
<td>1/1</td>
<td></td>
</tr>
</tbody>
</table>

Month  Intervention

*Oct '20  Two physicians have joined the system Sepsis PI team.
CMS Reporting – All Sepsis Measures

Note: Low numbers and inconsistent performance
Opportunity to Improve

• Transferred > Admitted

• What data was not being captured?

• Why is our data inconsistent
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.
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

<table>
<thead>
<tr>
<th>Concern for infection/sepsis</th>
<th>Concern for SEVERE sepsis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIRS (≥2) AND any organ dysfunction (any 1 of the following: lactate &gt;2, hypotension - SBP &lt;90 or MAP &lt;65, Cr &gt;2, Bill &gt;2, Pitt &lt;100/60; INR &gt;1.5 not on Act; or M - intubation, CPAP or BIPAP)</td>
<td>SIRS (≥2) AND any organ dysfunction (any 1 of the following: lactate &gt;2, hypotension - SBP &lt;90 or MAP &lt;65, Cr &gt;2, Bill &gt;2, Pitt &lt;100/60; INR &gt;1.5 not on Act; or M - intubation, CPAP or BIPAP)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lactate</th>
<th>Blood Cultures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactate &lt; 2: No repeat required</td>
<td>Blood cultures obtained prior to antibiotics</td>
</tr>
<tr>
<td>Lactate &gt; 2: Repeat ordered within 6h</td>
<td>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.</td>
</tr>
</tbody>
</table>

Please document "Time of noted delay if blood Cx not prior to Abx"[1](#). |

<table>
<thead>
<tr>
<th>Antibiotics</th>
<th>IVFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 hours</td>
<td><code>SBP &lt; 90 mmHg and/or MAP &lt; 65 mmHg and/or Lactate &gt; 4</code></td>
</tr>
<tr>
<td>Greater than 3 hours</td>
<td>Concerned 30 cc/kg bolus would be harmful for the patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IVFs</th>
<th>Contraindicated due to:</th>
</tr>
</thead>
<tbody>
<tr>
<td><code>SBP &lt; 90 mmHg and/or MAP &lt; 65 mmHg and/or Lactate &gt; 4</code></td>
<td>Concern for fluid overload</td>
</tr>
<tr>
<td>Concerned 30 cc/kg bolus would be harmful for the patient</td>
<td>Heart failure</td>
</tr>
<tr>
<td>Not indicated (no hypotension and/or lactate &lt; 4)</td>
<td>Renal failure</td>
</tr>
<tr>
<td>Blood pressure responded to lesser volume of fluid</td>
<td>Volume instead of 30 cc/kg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Volume instead of 30 cc/kg</th>
<th>250 ml crystalloid fluid bolus</th>
</tr>
</thead>
<tbody>
<tr>
<td>500 ml crystalloid fluid bolus</td>
<td>1000 ml crystalloid fluid bolus</td>
</tr>
</tbody>
</table>

---

[1](#) MONUMENT HEALTH
Results

PI project started July 2021
Results

CMS Reporting – All Sepsis Measures

Note: Increase in pass rate and decrease in fail rate

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

Severe Sepsis and Septic Shock
Severe Sepsis and Septic Shock Measure

Sepsis Mortality
Statewide Database
Lower is Better

- Facility
- HQIC Average
- Facility Median

<table>
<thead>
<tr>
<th>Reporting Month - Year</th>
<th>Facility</th>
<th>Avg HQIC</th>
<th>Avg</th>
<th>Num/Den</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan '22</td>
<td>84.99</td>
<td>91.11</td>
<td>92</td>
<td>0.2</td>
</tr>
<tr>
<td>Feb '22</td>
<td>84.99</td>
<td>91.25</td>
<td>91</td>
<td>0.1</td>
</tr>
<tr>
<td>Mar '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
<tr>
<td>Apr '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
<tr>
<td>May '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
<tr>
<td>Jun '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
<tr>
<td>Jul '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
<tr>
<td>Aug '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
<tr>
<td>Sep '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
<tr>
<td>Oct '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
<tr>
<td>Nov '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
<tr>
<td>Dec '22</td>
<td>91.34</td>
<td>91.34</td>
<td>92</td>
<td>0.1</td>
</tr>
</tbody>
</table>

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

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

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

- Facility
- HQIC Average
- Facility Median

<table>
<thead>
<tr>
<th>Reporting Month - Year</th>
<th>Facility</th>
<th>Avg HQIC</th>
<th>Num/Den</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr '21</td>
<td>9.99</td>
<td>7.11</td>
<td>2.22</td>
</tr>
<tr>
<td>May '21</td>
<td>20.83</td>
<td>7.06</td>
<td>6.04</td>
</tr>
<tr>
<td>Jun '21</td>
<td>5.88</td>
<td>6.57</td>
<td>2/34</td>
</tr>
<tr>
<td>Jul '21</td>
<td>0.00</td>
<td>6.37</td>
<td>0/27</td>
</tr>
<tr>
<td>Aug '21</td>
<td>10.81</td>
<td>5.53</td>
<td>4.07</td>
</tr>
<tr>
<td>Sep '21</td>
<td>2.78</td>
<td>6.81</td>
<td>1.08</td>
</tr>
<tr>
<td>Oct '21</td>
<td>2.63</td>
<td>7.13</td>
<td>1.06</td>
</tr>
<tr>
<td>Nov '21</td>
<td>2.63</td>
<td>6.96</td>
<td>1/08</td>
</tr>
<tr>
<td>Dec '21</td>
<td>8.57</td>
<td>7.28</td>
<td>3/15</td>
</tr>
<tr>
<td>Jan '22</td>
<td>6.90</td>
<td>7.14</td>
<td>2/29</td>
</tr>
<tr>
<td>Feb '22</td>
<td>10.00</td>
<td>7.14</td>
<td>2/20</td>
</tr>
<tr>
<td>Mar '22</td>
<td>7.80</td>
<td>6.73</td>
<td>2/26</td>
</tr>
<tr>
<td>Apr '22</td>
<td>0.00</td>
<td>6.93</td>
<td>0/24</td>
</tr>
<tr>
<td>May '22</td>
<td>0.00</td>
<td>6.39</td>
<td>0/26</td>
</tr>
<tr>
<td>Jun '22</td>
<td>12.90</td>
<td>6.79</td>
<td>4/31</td>
</tr>
<tr>
<td>Jul '22</td>
<td>3.13</td>
<td>6.81</td>
<td>1/32</td>
</tr>
<tr>
<td>Aug '22</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evaluation

• Improvement in both the 6-hour and the 3-hour bundle for patients admitted
• 17 months in a row Sturgis Hospital has been at 100% for the 3-hour bundle
• Opportunities remain with patients transferred to a higher level of care
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
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


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.
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

Patient admitted in active labor and delivered newborn

Immediately after delivery, mother blacked out, blood pressure dropped and went into septic shock

Mother in ICU to stabilize blood pressure; leaked spinal fluid from epidural site

Mother and baby boy reunited after 24 hours

Mother had to learn how to walk and use the bathroom again

Discharge after one-week stay; full recovery

Discharge instructions given but mother did not fully understand when or how to give herself heparin shot

Resolved by talking with healthcare professional; discontinue

Mother and baby both doing well and at home

Clinical team had to break clavicle and remove baby with forceps; not breathing for 20 seconds

Baby boy rushed to NICU; on cooling mat for three days

Met all milestones and full recovery after 24 days in NICU

Mother had to learn how to walk and use the bathroom again

Discharge after one-week stay; full recovery

Discharge instructions given but mother did not fully understand when or how to give herself heparin shot

Resolved by talking with healthcare professional; discontinue

Mother and baby both doing well and at home
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
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](#)
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
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
Thank You for Attending Today’s Event

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

**IPRO HQIC Team**
Lynda Martin, MPA, BSN, RN, CPHQ  
martini@qlarant.com
Rebecca Van Vorst, MSPH, CPHQ  
HQIC Project Manager  
RVanVorst@ipro.org  
View our Website

**Alliant HQIC Team**
Karen Holtz,  
MT (ASCP), MS, CPHQ  
Alliant Quality  
Karen.holtz@allianthealth.org  
View our Website

**Telligen HQIC Team**
Meg Nugent,  
MHA, RN  
HQIC Program Manager  
mnugent@telligen.com  
View our Website

**Compass HQIC Team**
Charisse Coulombe  
Compass  
Coulombec@ihconline.org  
View our Website

This material was prepared by the IPRO HQIC, a Hospital Quality Improvement Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication # IPRO-HQIC-Tsk56-23-305