Exploring Sepsis Strategies-Part 2: Care Coordination & Preventing Sepsis-Related Readmissions

Telligen, IPRO, Alliant, and Compass Joint HQIC Learning Event

September 30th, 2021

Please note, this event is being recorded

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Today's Agenda

- Welcome & Introductions
- National Data Discussion
- The Role of the Infection Preventionist in Preventing Sepsis-Related Readmissions
- Hospital and Long-Term Care Partnership to Prevent Sepsis-Related Readmissions
- Sepsis Transition of Care Resources
- Key Takeaways
- Q&A

Today's Objectives

- Understand the role of the Infection Preventionist in preventing sepsis-related readmissions.
- Hear about successful strategies for partnering with skilled nursing facilities to prevent sepsis-related hospital readmissions.
- Discuss challenges brought on by COVID-19 that affect care coordination and handoff to the next level of care
- Learn about project plans for overcoming current barriers to reducing sepsis readmissions

Welcome and Introduction of Today's Guest Speakers

Lisa Bromfield, MSN, RN
COVID-SNF Grant Resource Nurse
Frederick Health, Maryland
IPRO HQIC

Jackie Dinterman, M.A., LBSW, ACM
Director of Care Management
Frederick Health Hospital, Maryland
IPRO HQIC

Linda R. Greene, RN, MPS, CIC, FAPIC
Director Hospital Infection Prevention
UR Highland Hospital Rochester, NY
Compass HQIC

Elizabeth (Beth) Murray, M.Ed., RN, MCHES, HN-BC
Readmissions Project Manager
The Hospital and Health System Association of Pennsylvania
IPRO HQIC

Sepsis & Readmissions: Why Focus on it Now?

Karen Holtz, MT (ASCP), MS, CPHQ, Alliant HQIC

Charisse Coulombe, MS, MBA, CPHQ, Compass HQIC

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Sepsis and Readmissions – National Trends

- Sepsis is responsible for the most readmissions to a hospital within 30 days
- Each year, more than 191,000 sepsis patients are readmitted to the hospital within 30 days leading to an annual cost of more than $3.1 billion a year
- One study found that 17.5% of sepsis survivors were readmitted to the hospital within 30 days, with most occurring within the first two weeks
- Survivors of sepsis are more likely to be discharged to a place other than home, such as a skilled nursing facility

References:
1. https://www.sepsis.org/news/readmission-to-hospital-after-sepsis-a-qa-with-dr-hallie-prescott/
2. https://www.sepsis.org/news/sepsis-alliance-responds-to-study-revealing-sepsis-as-number-one-cause-of-hospital-readmissions/
3. https://media.jamanetwork.com/news-item/sepsis-a-leading-cause-of-hospital-readmission/
4. https://www.healthleadersmedia.com/clinical-care/cost-sepsis-readmissions-estimated-more-16000-patient

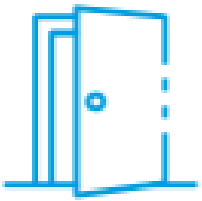
Sepsis Readmissions – National Trends

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 readmissions 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 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.

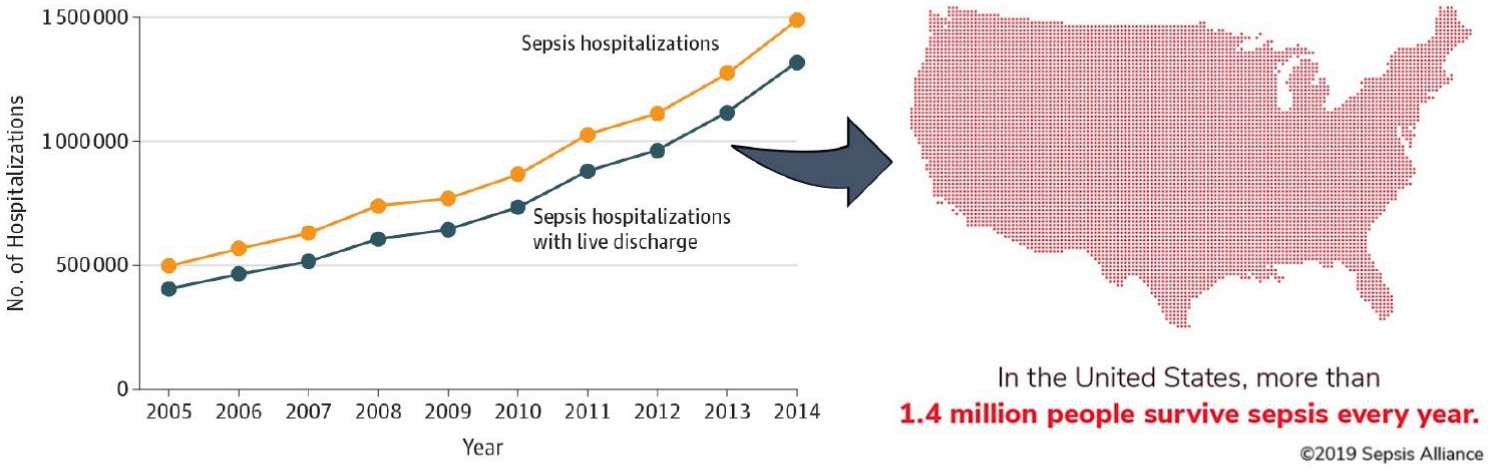
AFRICAN AND NATIVE AMERICANS ARE MORE LIKELY TO BE READMITTED

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/

Sepsis and Readmissions – National Trends

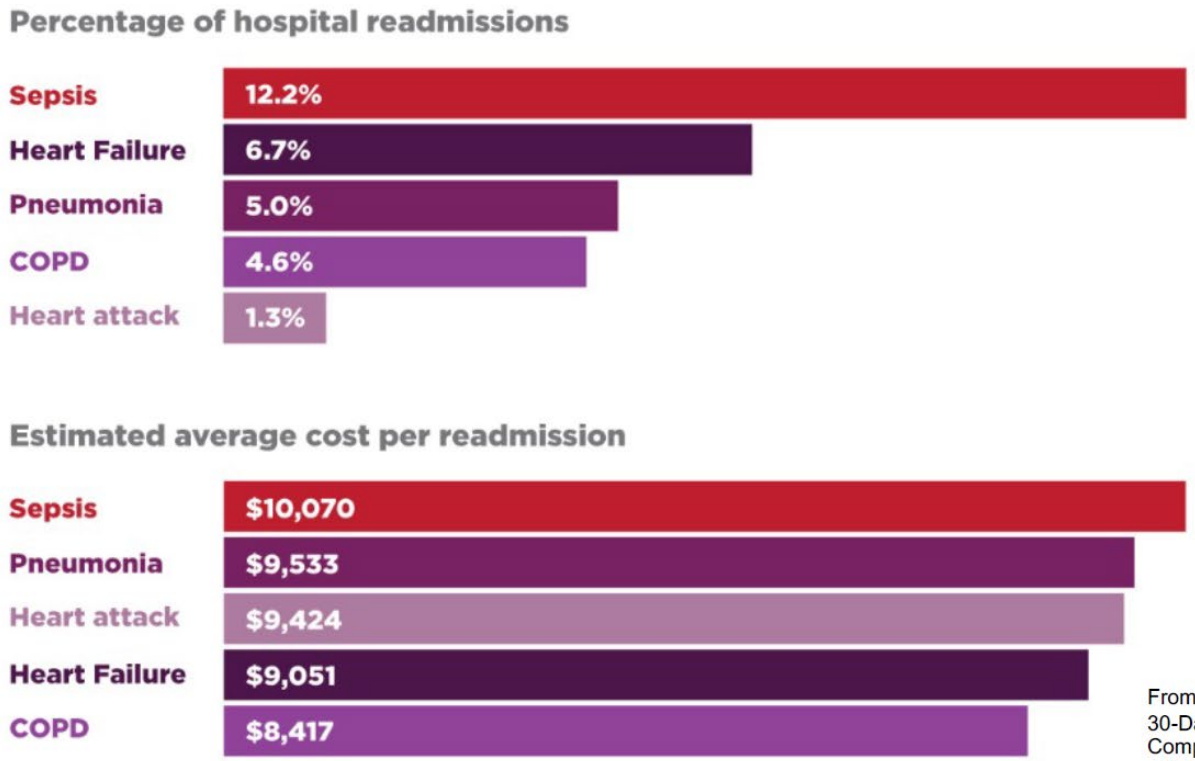
Increasing numbers of sepsis survivors



From: Enhancing Recovery From Sepsis: A Review. JAMA. 2018;319(1):62-75
Healthcare Cost and Utilization Project. AHRQ
Sepsis Alliance sepsis.org

Sepsis and Readmissions – National Trends

Hospital readmissions and healthcare costs after sepsis

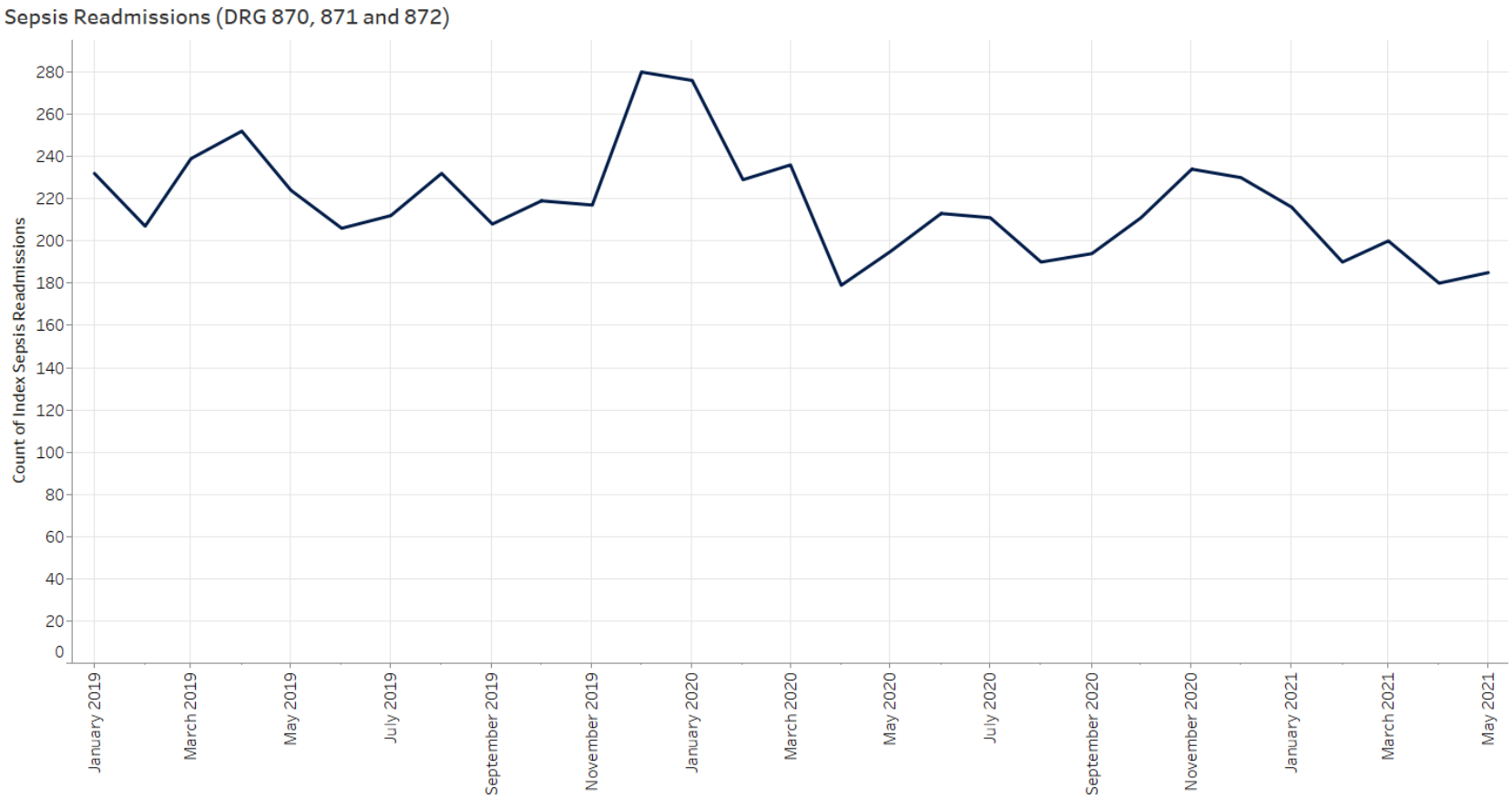


1 in 3 readmitted within 90 days

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

Sepsis Diagnosis Related Group (DRG) Data



The Role of the Infection Preventionist in Ensuring Safe Discharge of Sepsis Patients and Preventing Readmissions

Linda Greene, RN, MPS, CIC, FAPIC

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Role of the Infection Preventionist

- Facilitator
- Collaborator
- Evaluator
- Patient Safety & Quality Expertise

Reasons for Sepsis Readmissions

- Studies identified an increased risk of sepsis within 90 days of discharge among patients with exposure to high risk or increased quantities of antibiotics during hospitalization.
- A significant proportion of inpatient antimicrobial use may be unnecessary
- Study builds on previous evidence suggesting that increased stewardship efforts in hospitals may not only prevent antimicrobial resistance, CDI and other adverse effects, but also reduce unwanted outcomes potentially related to disruption of the microbiota, including sepsis.

Details

- Antibiotics are essential treatments for many hospitalized patients. While over half of hospitalized patients receive an antibiotic an estimated 30–50% of antibiotic use in hospitals is inappropriate.
- Widespread use of antibiotics not only leads to selection for drug resistance and increases risk for *Clostridium difficile* infection (CDI), but also may increase a patient's risk for later development of sepsis.

Study Findings

- Found that hospital events, such as infection or CDI further increased the rate increased the rate of readmission
- Infection and CDI, disrupts the patient's microbiota in part due to anti-bacterial agents.
- Supports the hypothesis by showing that increased antibiotic exposure, or exposure to specific anti-bacterial agents more likely to disrupt the microbiota are associated with an increased risk in severe sepsis in the 90 days following hospital discharge.

Clin Infect Dis. 2018;66(7):1004-1012. doi:10.1093/cid/cix947

Study Conclusions

- Study observed a significant increase in severe sepsis and septic shock within 90 days of discharge for patients exposed to antibiotics in the hospital likely to disrupt the patient's microbiota.
- Given that a significant proportion of inpatient antimicrobial use may be unnecessary
- Study builds on a growing evidence base suggesting that increased stewardship efforts in hospitals may not only prevent antimicrobial resistance, CDI and other adverse effects, but also reduce other unwanted outcomes potentially related to disruption of the microbiota, including sepsis.

Cause of readmission	Total n=205
Infectious etiology	107 (52.20%)
Cardiovascular	26 (12.68%)
Gastrointestinal, hepatic and pancreatic diseases	21 (10.24%)
Musculoskeletal	12 (5.85%)
Respiratory system other than pneumonia	12 (5.85%)
CNS	8 (3.90%)
Genitourinary	8 (3.90%)
Hematological	3 (1.46%)
Psychiatric illness	2 (0.98%)
Neoplasm	2 (0.98%)
Opioid Overdose	2 (0.98%)
Alcohol withdrawal	1 (0.49%)
Lithium toxicity	1 (0.49%)

Sepsis and Antibiotic Stewardship

Rapid Recognition

De-escalation therapy Narrowing treatment

Intervention

Synergy

The Multidisciplinary Team

3 Main Areas of Focus

- Preventing HAIs – Bundle Compliance, Device Utilization
- Stewardship Efforts
- Collaborating on Patient Education

INFECTION CONTROL & HOSPITAL EPIDEMIOLOGY APRIL 2018, VOL. 39, NO. 4

APIC/SHEA/SIDP ANTIMICROBIAL STEWARDSHIP POSITION PAPER

COMMENTARY

Antimicrobial Stewardship and Infection Prevention—Leveraging the Synergy: A Position Paper Update

Mary Lou Manning, PhD, CRNP, CIC, FSHEA, FAPIC;[1] Edward J. Septimus, MD, FIDSA, FACP, FSHEA;[2] Elizabeth S. Dodds Ashley, PharmD, MHS, BCPS;[3] Sara E. Cosgrove, MD, MS, FSHEA;[4] Mohamad G. Fakih, MD, MPH, FIDSA, FSHEA;[5] Steve J. Schweon, MPH, MSN, RN, CIC, HEM, FSHEA, FAPIC;[6] Frank E. Myers, MA, CIC, FAPIC;[7] Julia A. Moody, SM-ASCP[8]

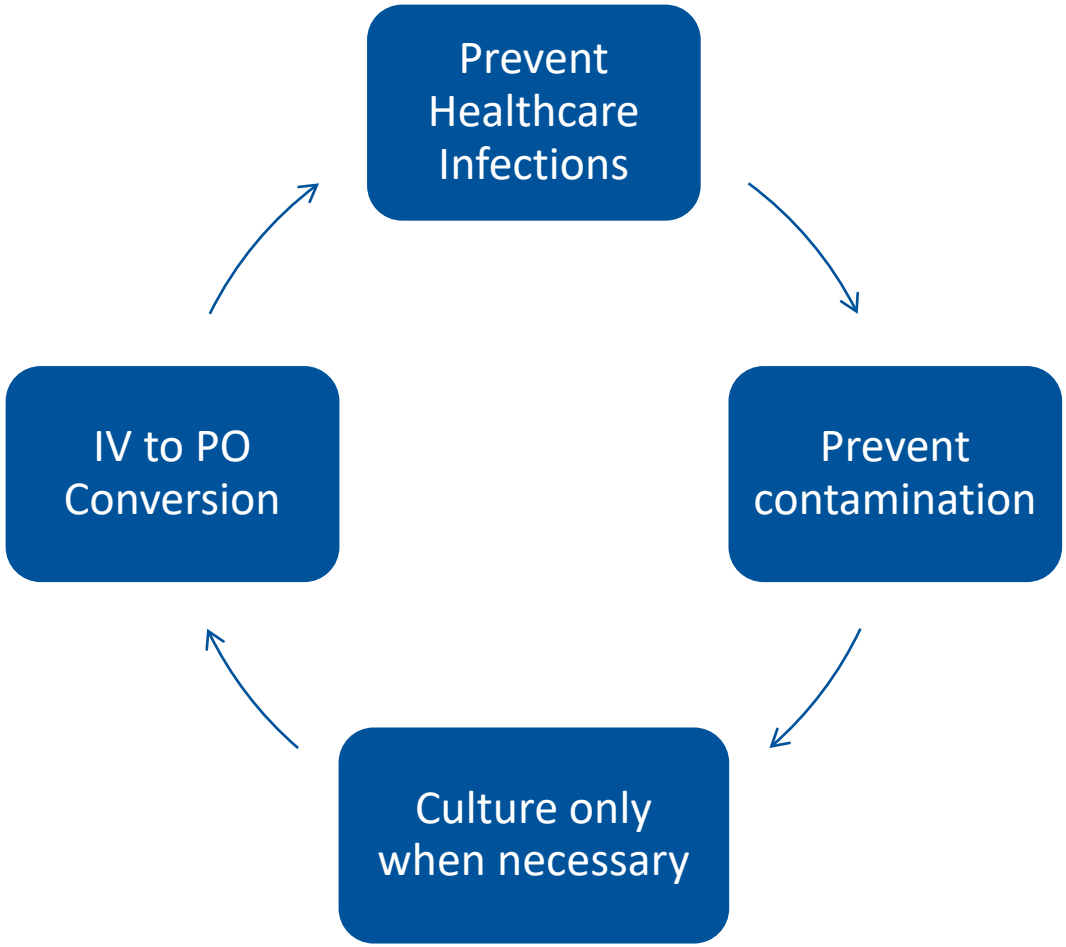
TABLE 3. Categories of Knowledge and Skills Required for Antimicrobial Stewardship Leaders[22]

1. General principles of antimicrobial stewardship
2. Approaches to stewardship interventions
3. Microbiology and laboratory diagnostics
4. Common infectious syndromes
5. Measurement and analysis
6. Informatics/information technology
7. Program building and leadership
8. Special populations and nonacute hospital settings
9. Infection control

Nursing and IP Initiatives

- Appropriate culture collection (Urine and Blood)
- Patient response
- IV to PO conversion
- Lab Reports and sensitivities
- Prevent other HAIs – CAUTI, CLABSI
- Communication to providers

Antibiotic Stewardship



Clinical Trials: Discharge

- Clinical trial evidence to support specific post discharge rehabilitation treatment
- Experts recommend referral to physical therapy to improve exercise capacity, strength, and independent completion of activities of daily living
- This recommendation is supported by an observational study involving 30, 000 sepsis survivors that found that referral to rehabilitation within 90 days was associated with lower risk of 10-year mortality compared with propensity-matched controls (adjusted HR, 0.94; 95% CI, 0.92-0.97, P < .001).

Recovery

In the months after hospital discharge for sepsis, management should focus on

- (1) identifying new physical, mental, and cognitive problems and referring for appropriate treatment,
- (2) reviewing and adjusting long-term medications, and
- (3) evaluating for treatable conditions that commonly result in hospitalization, such as infection, heart failure, renal failure, and aspiration. For patients with poor or declining health prior to sepsis who experience further deterioration after sepsis, it may be appropriate to focus on palliation of symptoms

Prescott HC, Angus DC. Enhancing Recovery From Sepsis: A Review. JAMA. 2018 Jan 2;319(1):62-75..


COMMUNICATION


NEWS

Building a Collaborative: A Work of Heart

Jackie Dinterman, MA, LBSW, ACM

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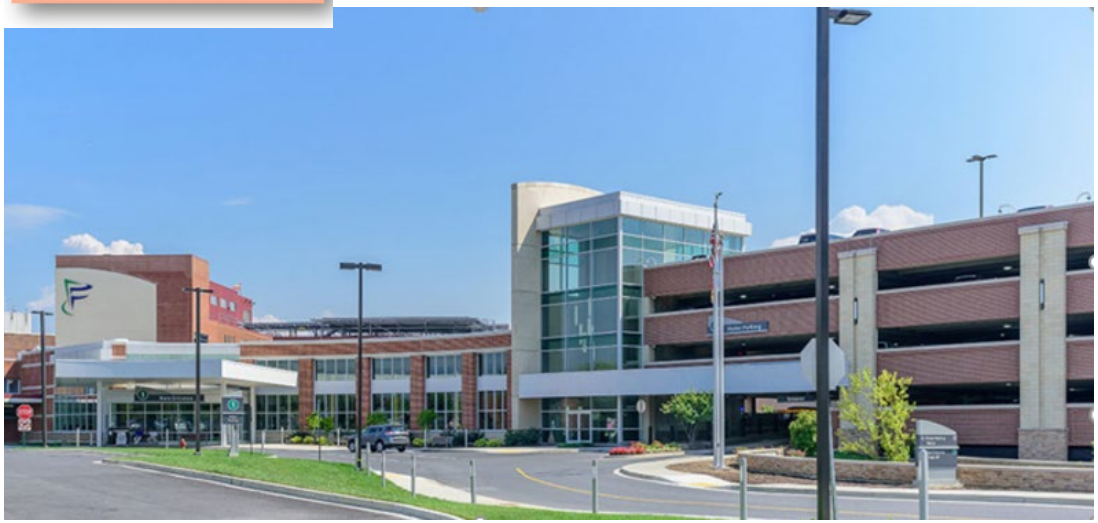
Frederick Health



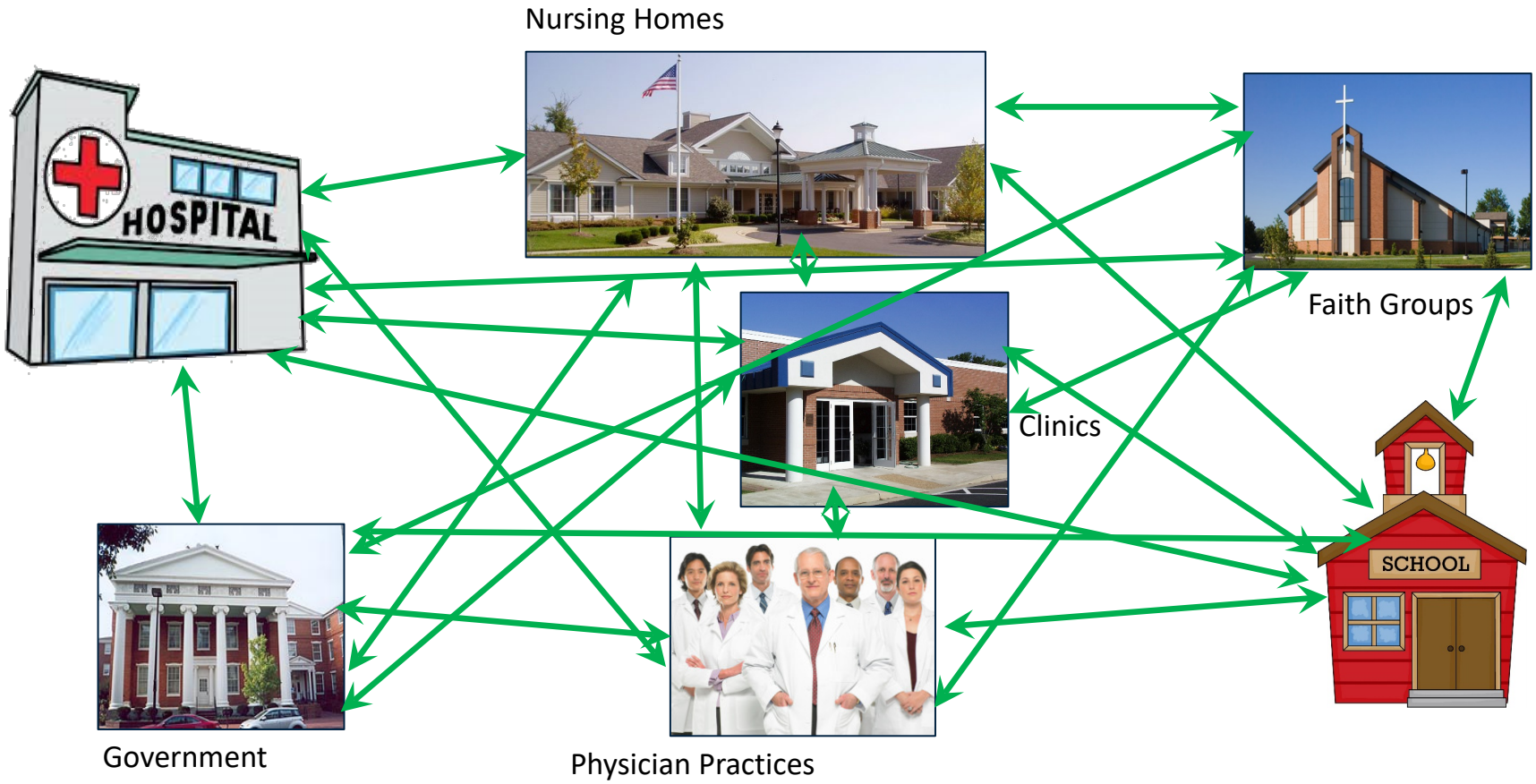
- Frederick Health Hospital (269 licensed beds), Not-for-profit
- Frederick Health Medical Group, Frederick Health Employer Solutions, Frederick Health Home Care, Frederick Health Hospice, Cancer Center
- Frederick County: 40% population growth over the past 25 years resulting in an additional 95,000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

Building a Skilled Nursing Facility/Assisted Living/Frederick Health Hospital Collaborative

- Created in 1997, to improve communication among post acute providers
- 10 SNF's/LTC facilities, 8 assisted livings (ALs)
- Meeting at hospital at lunchtime – first ½ hour networking; 1 hour meeting
- Planned for bi-annual meetings; quickly moved to quarterly, then monthly
- Added assisted livings to group in 2000 because there were similar issues
- Saved time by working together on process improvement
- Improved consistency of information to care for our patients
- Networked with area facilities so we could work on difficult issues
- Moved meetings from hospital to NH's and AL's (Post COVID now back to Frederick Health building)

Frederick Community and Philosophy

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



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
- Remind speakers of our mission
- Be the advocate for the nursing facilities and assisted living
- Can learn from all facilities

Strategies for Support

- Reach out to suggest collaborative to partner on reducing readmissions
- Have a hospital champion
- Other departments need input

Involvement on Hospital Committees

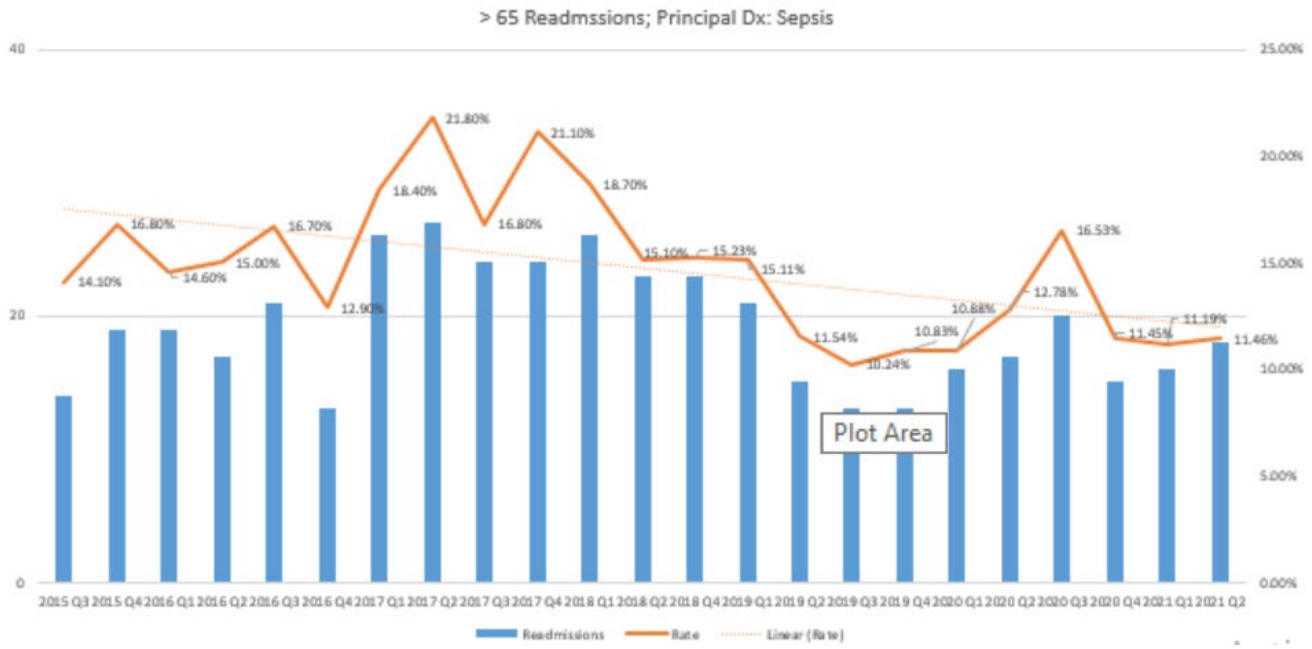
- Project Discharge
- Heart Failure Readmissions Collaborative
- Safe from Falls Initiative
- Safe Surgery Initiative (SSI)
- Readmission Steering Committee
- Clinical Care Map development:
  - HF
  - COPD
  - Sepsis

Collaborative Accomplishments

- Developed universal FMH/NH/AL transfer form
- Developed physicians order form
- Voice care reporting – transfer handoff
- 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
- Infectious disease screening education - increase compliance
- **Partnering with CMS QIO Care Transitions Improvement Consultant and NH Improvement Consultant**
- **Successful sepsis readmission reduction initiative**

Sepsis Data after Start of Project and Today

> 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 and 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

Tools Shared

Stop and Watch
Early Warning Tool

INTERACT Version 4.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him

S	Seems different than usual
T	Talks or communicates less
O	Overall needs more help
P	Pain – new or worsening; Participated le
a	Ate less
n	No bowel movement in 3 days; or diarrhe
d	Drank less
W	Weight change
A	Agitated or nervous more than usual
T	Tired, weak, confused, or drowsy
C	Change in skin color or condition
H	Help with walking, transferring, toileting more

☐ Check here if no ch
while monitoring h

Patient / Resident

Your Name

Reported to *Date and Tim*

Nurse Response *Date and Tim*

Nurse's Name

SBAR Communication Form
and Progress Note for RNs/LPN/LVNs

INTERACT Version 4.0 Tool

Before Calling the Physician / NP / PA / other Healthcare Professional:

☐ **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, O_2 saturation and finger stick glucose for diabetics
☐ **Review Record:** Recent progress notes, labs, medications, other orders
☐ **Review an INTERACT Care Path** or **Acute Change in Condition File Card**, if indicated
☐ **Have Relevant Information Available when Reporting**
(i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs observed and evaluated is/are _____
This started on ___/___/___ Since this started it has gotten: ☐ Worse ☐ Better ☐ Stayed the same
Things that make the condition or symptom **worse** are _____
Things that make the condition or symptom **better** are _____
This condition, symptom, or sign has occurred before: ☐ Yes ☐ No
Treatment for last episode (if applicable) _____
Other relevant information _____

BACKGROUND

Resident Description
This resident is in the facility for: ☐ Long-Term Care ☐ Post Acute Care ☐ Other: _____
Primary diagnoses _____
Other pertinent history (e.g. medical diagnosis of CHF, DM, COPD) _____

Medication Alerts
☐ Changes in the last week (describe) _____
☐ Resident is on (Warfarin/Coumadin) Result of last INR: _____ Date ___/___/___
☐ Resident is on other anticoagulant (direct thrombin inhibitor or platelet inhibitor)
Resident is on: ☐ Hypoglycemic medication(s) / Insulin ☐ Digoxin
Allergies _____

Vital Signs
BP _____ Pulse _____ (or Apical HR _____) RR _____ Temp _____ Weight _____ lbs (date ___/___/___)

Source: http://www.pathway-interact.com/interact-tools/interact-tools-library/interact-version-4-0-tools-for-nursing-homes/

Nursing Home Capabilities List

INTERACT Version 4.0 Tool

st is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs ke off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Key Contact _____

'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Nursing Services		
Frequent vital signs (e.g. every 2 hrs)	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids (initiation and maintenance)	Y	N
IV Antibiotics	Y	N
IV Meds – Other (e.g. furosemide)	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Isolation (for MRSA, VRE, etc....)	Y	N
Surgical Drain Management	Y	N
Tracheostomy Management	Y	N
Analgesic Pumps	Y	N
Dialysis	Y	N
Advanced CPR (ACLS capability)	Y	N
Automatic Defibrillator	Y	N
Pharmacy Services		
Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N
Other Specialized Services (specify)		

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Tools Shared

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:

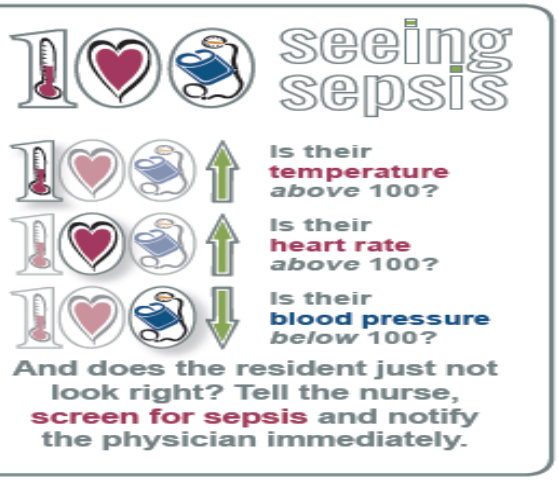
- Prepare transfer sheet
- Call ambulance
- Call in report to hospital
- Report positive sepsis screen

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

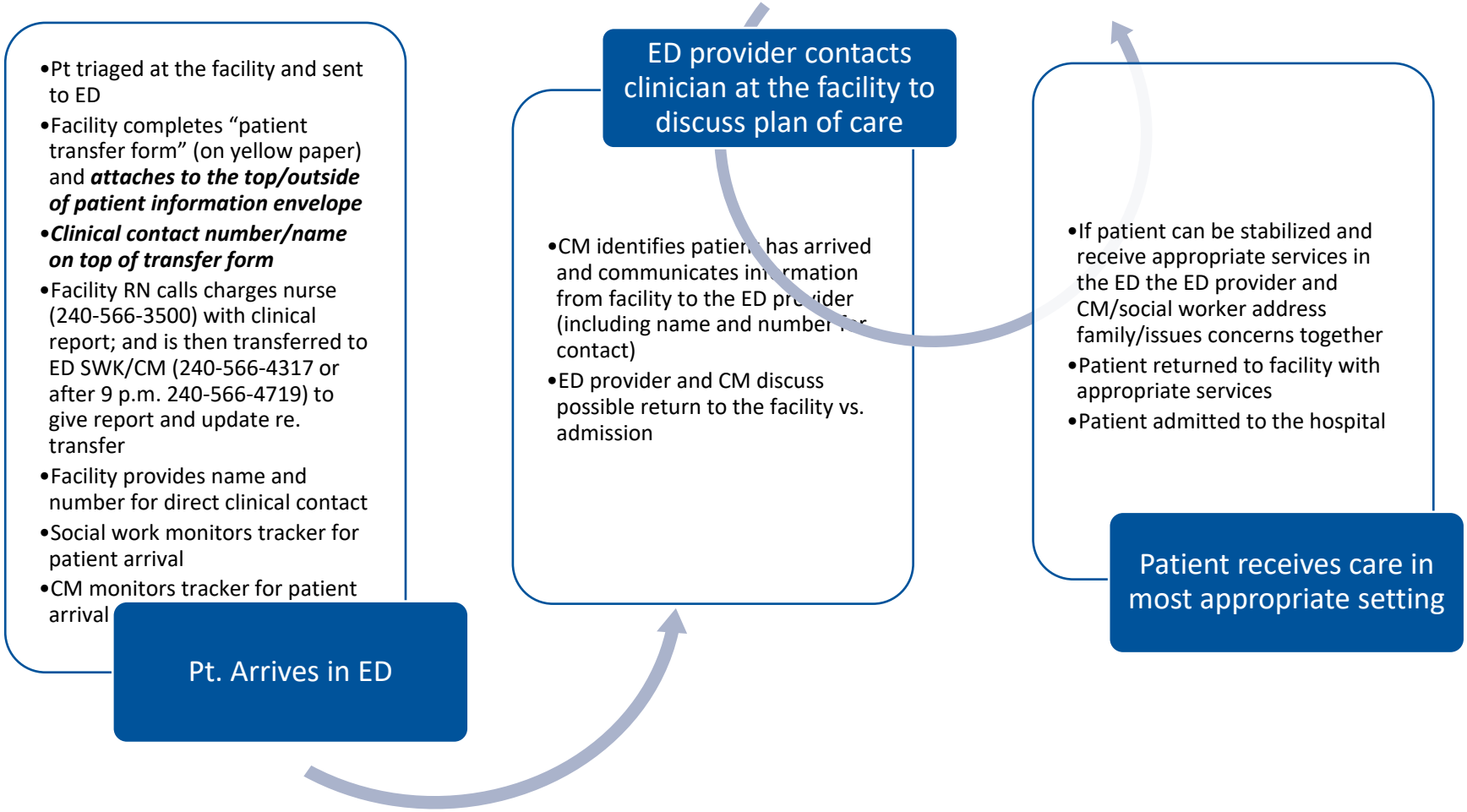
- Labs: CBC w/diff, lactate level (if able)
- UA/UC, blood cultures, as able from 2 sites, not from lines
- Establish IV access for IV 0.9% @ 30ml/kg
- Administer IV, PO or IM antibiotics
- Monitor for worsening in spite of treatment, such as:
  - Urine output <400ml in 24 hours
  - SBP <90 despite IV 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!

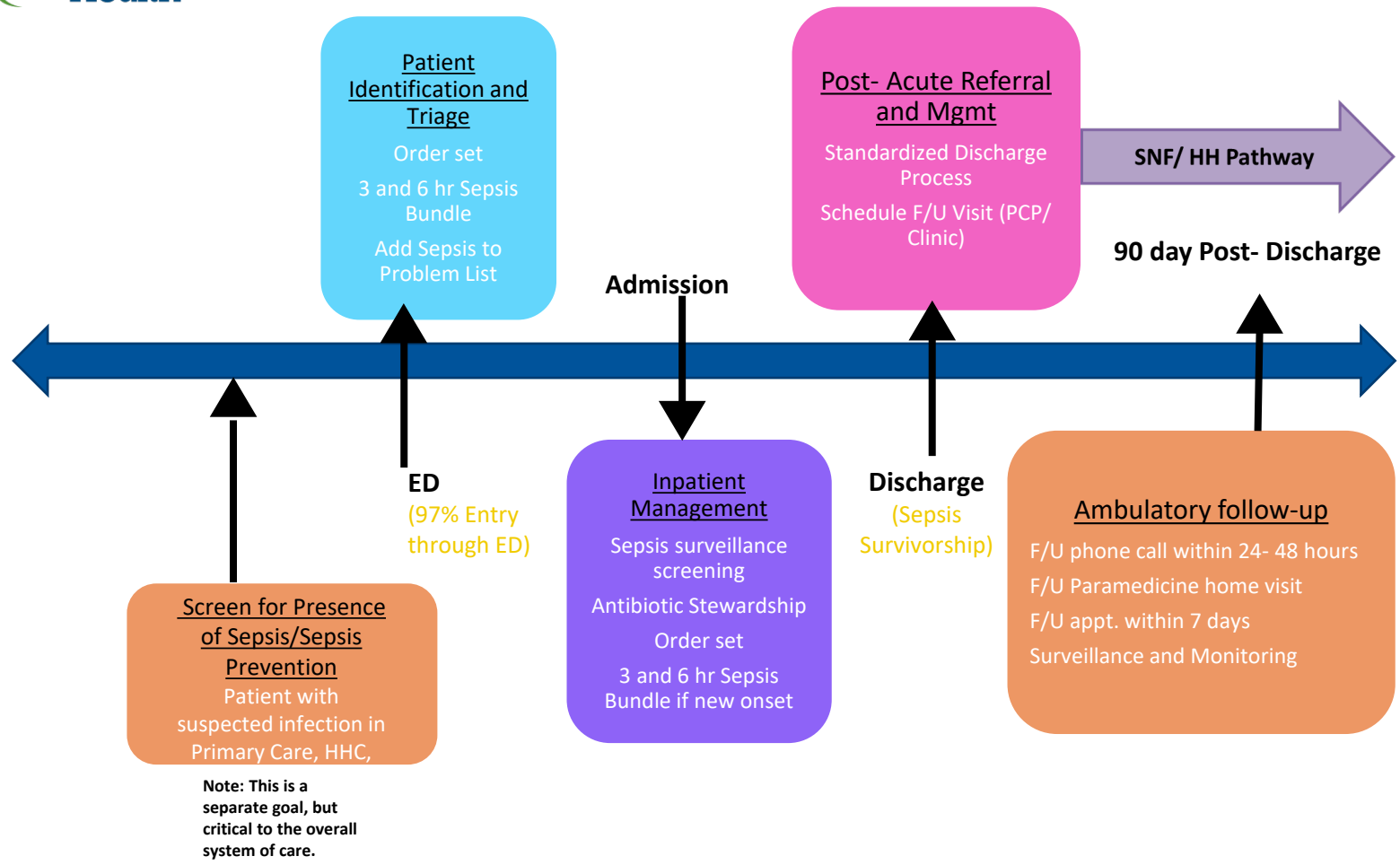


Transition Flow- Post Acute Facility to Emergency Department



Frederick Health

SEPSIS SYSTEM OF CARE



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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

- **TeleSupportive Services implemented quickly to support nursing homes and assisted living facilities**

Relationships already built = Shared Goals = Shared Successes

Using Relationships, Communication and Education to Decrease Sepsis Morbidity, Mortality and Readmissions from Long-Term Care Facilities

Lisa Bromfield, MSN, RN

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COVID-19 – 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

Enhance Collaboration Around Transfers

- Recognize problems that affect transfer decisions & outcomes
  - Completed MOLST* (POLST) and 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

Positive Communication Improves Relationships

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

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
  - Recognize possible sepsis and begin protocol

Are Staff at Facilities Looking for Sepsis?

- Questions we asked in a survey
  - Sepsis surveillance protocol or tool?
  - Education around sepsis risk factors?
  - Education around sepsis recognition?
  - 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 CMS expect them to address readmissions – 2022?
    - What is the real cost?

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
  - Know how many folks sent from LTC to R/O sepsis
  - How many of those folks were admitted
  - Which facilities they came from
  - How many folks admitted with sepsis were sent for something else?
  - If not sepsis, what is the presenting concern for folks 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

Enjoy Collaborating! *Thank you for your time & your work!*

Preventing Sepsis & Readmissions Using Patient/Family & Care Provider Education, Fact Sheets, Hand-off Communication & Discharge Checklists

Elizabeth (Beth) Murray, M.Ed., RN, MCHES, HN-BC

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Healthcentric Advisors ■ Qlarant
Kentucky Hospital Association
Q3 Health Innovation Partners
Superior Health Quality Alliance
Telligen QI Connect™
HQIC Hospital Quality Improvement Contractors
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The Hospital and Healthsystem Association of Pennsylvania Sepsis Fact Sheets

Nine sepsis fact sheets were developed to improve the transition of care for patients with a diagnosis of sepsis

- Post-Acute Care Facilities
- Hand-Off Communications
- Patient Post-Discharge
- Patient Post-Discharge Action Plan
- Patient and Family Education
- Health Care Providers
- Acute Care Nursing Staff
- Home Care Staff
- Patient Discharge checklist for Acute Care Staff

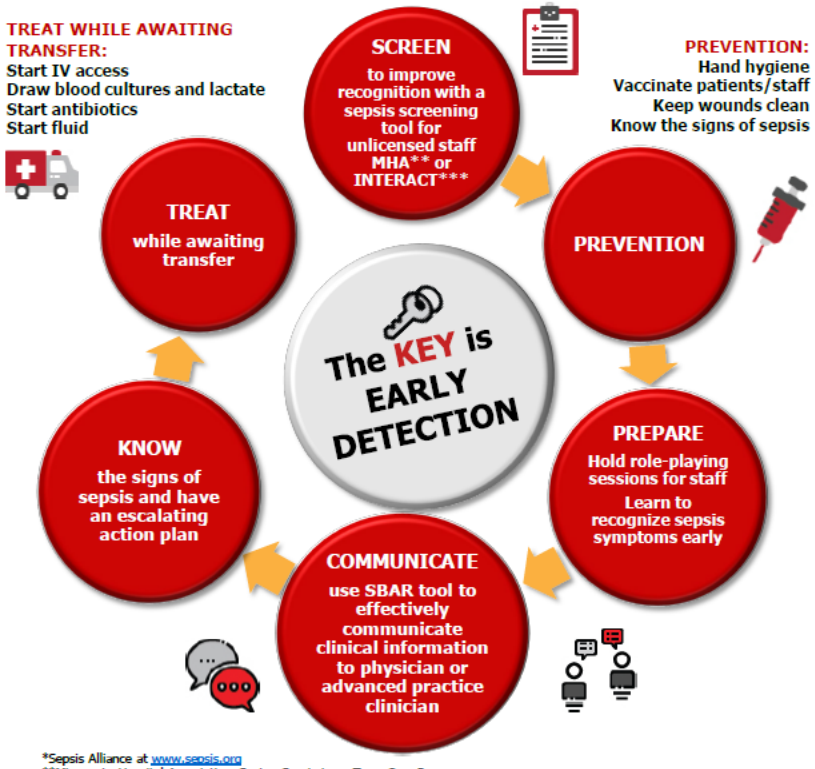
SEPSIS FACT SHEET
Post-Acute Care Facilities

THE SIGNS OF SEPSIS*

Shivering **E**xtreme pain **P**ale skin **S**leepy "**I** feel like I might die" **S**hort of breath

TREAT WHILE AWAITING TRANSFER:
Start IV access
Draw blood cultures and lactate
Start antibiotics
Start fluid

PREVENTION:
Hand hygiene
Vaccinate patients/staff
Keep wounds clean
Know the signs of sepsis



*Sepsis Alliance at www.sepsis.org
**Minnesota Hospital Association *Seeing Sepsis Long Term Care Resources*
***INTERACT *Stop and Watch Early Warning* and *SBAR Communication* tools

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SEPSIS FACT SHEET
Hand-Off Communication

Acute care hospital ➡ Post-acute care facility

What You Need To Know If Your Patient Had Sepsis

Sepsis survivors may be discharged with new medical problems and have trouble with routine tasks.

When a sepsis survivor is discharged to a post-acute facility, the following should be provided:

Facility-to-facility communication

Say "sepsis" in the discharge summary—include source, organism, and antibiotics

Medication reconciliation and dosage adjustment if necessary

Surveillance for a new or recurrent infection post-discharge

Life After Sepsis Video:
https://youtu.be/HIk64wdy44Q
or search "Sepsis Alliance Life after Sepsis"

SEPSIS SURVIVORS ARE AT RISK

Cognitive disability
Forgetfulness/concentration
Anxiety and depression
Health deterioration
Chronic disease management
Immunosuppression
Readmission within 30 days often with another infection
Decreased quality of life
Early mortality

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SEPSIS FACT SHEET

Patient Post-Discharge

So you had sepsis...now what?

MONITOR YOUR HEALTH DAILY

My heartbeat and breathing are normal for me

I do not have a fever

- Take temperature twice a day

I do not feel hot or cold

My energy level is normal for me

My thinking is clear

I feel well

My infection is resolving

Any open skin is healing

My heartbeat or breathing is faster than normal

I have a slight fever (100°F – 100.4°F)

I have chills/shivering

I am tired and it is difficult to do my normal activities

My thinking is slow

I do not feel well

My infection is not getting better

My area of open skin looks different

Contact Primary Care for an urgent visit

My heartbeat or breathing is very fast

I have a fever (100.5°F or greater)

My temperature is below 96.8°F

My skin is pale or nails are blue

I am very tired and cannot do my daily activities

I am confused or my caregivers tell me I am not making sense

I feel sick

My open skin is red, painful, smells, or has pus

Go NOW to Urgent Care or Emergency Room or call 911

TAKE ACTION!

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SEPSIS FACT SHEET

Patient Post-Discharge Action Plan

My heartbeat or breathing is very fast

I have a fever (100.5°F or greater)

My temperature is below 96.8°F

My skin is pale or nails are blue

I am very tired and cannot do my daily activities

I am confused or my caregivers tell me I am not making sense

I feel sick

My open skin is red, painful, smells, or has pus

Note to clinicians:
Please complete and review this Action Plan with patient and provide at discharge

For patients experiencing concerning signs of symptoms

WHAT TO DO:

Get medical care immediately and ask **"Could this be sepsis?"**

☐ **Go NOW to Urgent Care**_____

Located at _____

_____

☐ **Go NOW to Emergency Room**_____

Located at _____

_____

☐ **Call 911**

KNOW THE SIGNS OF SEPSIS*

Shivering Extreme pain Pale skin Sleepiness
'I feel like I might die' Shortness of breath

Sepsis is a medical emergency—ACT FAST!

LEARN MORE: www.cdc.gov/sepsis
*Sepsis Alliance at www.sepsis.org

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SEPSIS FACT SHEET

Patient and Family Education

AWARENESS—
THE CURE FOR SEPSIS!

THE SIGNS OF SEPSIS*

Shivering
Extreme pain
Pale skin
Sleepiness
'**I** feel like I might die'
Shortness of breath

ANYONE CAN GET SEPSIS

Germs cause an infection and, if not stopped, **any infection can lead to sepsis.** Sepsis is the body's extreme response to an infection, causing your organs to shut down one by one and can be deadly.

Those at highest risk for sepsis are:
- Children less than one year old
- Elderly greater than 60 years old
- Those with chronic conditions or weak immune systems

WAYS TO PREVENT SEPSIS

1. Prevent infection and get vaccinated
2. Wash your hands often and keep cuts clean
3. Know the signs of sepsis
4. **Act fast** if you have an infection that is not getting better or is getting worse

TIME MATTERS

It's a race against the clock!

Sepsis is treatable with antibiotics but the more time you spend without the antibiotics, the less time you have to fight for your life.

Get medical care immediately and ask your health care provider "Could my infection be leading to sepsis?"

LIFE AFTER SEPSIS

More patients are surviving sepsis but many suffer from new problems:
- Memory loss
- Anxiety or depression
- Weakness and difficulty with routine tasks
- Difficulty sleeping
- Recurrent infection
- Medical setbacks from chronic conditions of the heart, lung, or kidney

HOW CAN I HELP MYSELF RECOVER?

- Set small goals for yourself—like bathing
- Rest to rebuild your strength
- Eat a balanced diet
- Exercise as you feel up to it—like walking
- Surveillance helps
  - Watch for signs of new or repeat infection
  - Take your temperature twice a day

LEARN MORE

www.cdc.gov/sepsis
*Sepsis Alliance at www.sepsis.org

SEPSIS IS A MEDICAL EMERGENCY!

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SEPSIS FACT SHEET

Health Care Providers

Patients with a sepsis diagnosis are at higher risk for:

Exacerbation of chronic diseases
Immunosuppression
Recurrent infections
Cognitive impairments
Anxiety and depression
Physical disability
Early mortality

Say "SEPSIS"
Call it what it is so more patients survive

SEPSIS AND BEHAVIORAL HEALTH

Of Pennsylvanians discharged with one of the following diagnoses—heart failure, sepsis, pneumonia, COPD, stroke, or ESRD—sepsis patients had the highest volume of behavioral health comorbidities. Anxiety and depression were identified most frequently.

Primary care sites and providers should plan to manage behavioral health comorbidities, at least for an interim, until patients that require a higher level of care can secure a provider.

FOCUS ON POTENTIALLY PREVENTABLE CONDITIONS AFTER DISCHARGE

- Infection
- Congestive heart failure
- Acute renal failure
- COPD exacerbations
- Aspiration

ENHANCING SEPSIS SURVIVORSHIP

- ✓ Timely and effective sepsis treatment
- ✓ Early mobility in hospital
- ✓ Screen for physical and mental impairment at discharge, and at first outpatient visit
- ✓ Review medications and dosages at discharge—involve pharmacy
- ✓ Vaccinate patients
- ✓ Educate patients about sepsis diagnosis, recovery expectations and post-sepsis syndrome
- ✓ Promote functional recovery—refer to rehab
- ✓ Keep it simple at discharge
- ✓ Refer patients to support groups
- ✓ Schedule early (<7 day) follow-up visit after discharge
- ✓ Complete discharge summary within 48 hours so available to primary care provider
  - Document sepsis, source, and antibiotics
- ✓ Prescribe home health services if patient is unable to manage medications at home
- ✓ Encourage self-monitoring for signs of infection
- ✓ Listen to your patient
- ✓ Discuss goals of care with patient
  - Consider palliative focus for patients with declining health prior to sepsis

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SEPSIS FACT SHEET
Acute Care Nursing Staff

Use SBAR *Situation-background-assessment-recommendation* method of communication for clinical report to physicians

Use **Teach Back** for sepsis discharge instruction—use video/visual resources

Say "SEPSIS" Call it what it is so more patients survive

SIGNS OF SEPSIS*

Shivering
Extreme pain
Pale skin
Sleepiness
'I feel like I might die'
Shortness of breath

ENHANCING SEPSIS SURVIVORSHIP

Sepsis survivors are at risk for cognitive, functional, and medical disabilities

- Encourage early mobility in hospital
- Ensure medication and dosage reconciliation at time of discharge
- Educate patient and family about signs of sepsis, expectations for recovery and post-sepsis syndrome
- Listen to the patient

EMPHASIZE INFECTION PREVENTION

- Hand hygiene
- Wound care
- Vaccinations for flu, pneumonia, others
- Take medications as prescribed

ENSURING A SUCCESSFUL DISCHARGE

- Provide self-monitoring tool for home
  - ✓ Review symptom inventory
  - ✓ Take body temperature
  - ✓ Review who to call and where to go for help
- Provide an action plan
  - ✓ Include number a patient should call
  - ✓ Identify where a patient should go for help
  - ✓ For severe symptoms, call 911
- Prior to discharge, schedule follow-up appointment (within 7 days of discharge)
- Discuss nutrition & hydration—give examples
- Call discharged sepsis patients within 48 hours to confirm:
  - ✓ Patient has medication/antibiotics
  - ✓ Patient has follow-up appointment
  - ✓ Home service has visited, if applicable
  - ✓ If there are changes in health or mood

MORE INFORMATION

www.cdc.gov/sepsis
*Sepsis Alliance at www.sepsis.org

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SEPSIS FACT SHEET
Home Care Staff

STOP SEPSIS!

KNOW THE SIGNS OF SEPSIS + ACT FAST

SIGNS OF SEPSIS*

Shivering
Extreme pain
Pale skin
Sleepiness
'I feel like I might die'
Shortness of breath

SEPSIS SURVIVORS ARE AT RISK

- Cognitive impairment—Forgetfulness/concentration
- Anxiety and depression
- Health deterioration
- Chronic disease management
- Immunosuppression
- Readmission within 30 days often with another infection
- Decreased quality of life
- Early mortality

ASSESS THE SEPSIS SURVIVOR

- Watch for changes in mood
- Discuss good nutrition—give examples
- Discuss hydration—encourage water
- Monitor if medications are being taken as prescribed
- Watch for changes in open skin areas
- Observe for functional, cognitive or medical decline
- Listen to the patient

PATIENT KNOWS ACTION PLAN

- Call 911 or xxx-xxx-xxxx
- Go to an emergency department or urgent care site

EMPHASIZE INFECTION PREVENTION

- Hand hygiene
- Wound care
- Vaccinations

MORE INFORMATION

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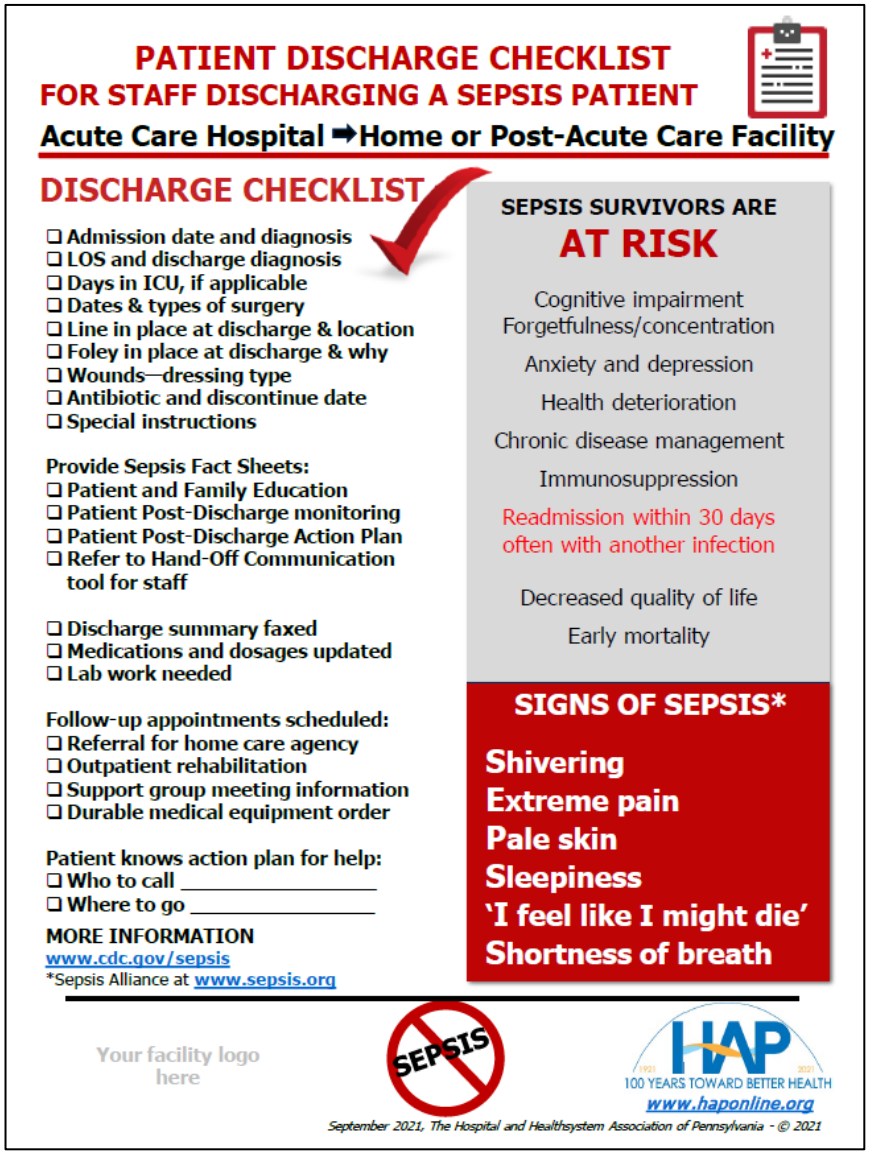

PATIENT DISCHARGE CHECKLIST
FOR STAFF DISCHARGING A SEPSIS PATIENT
Acute Care Hospital ➡Home or Post-Acute Care Facility

DISCHARGE CHECKLIST

- ❑ Admission date and diagnosis
- ❑ LOS and discharge diagnosis
- ❑ Days in ICU, if applicable
- ❑ Dates & types of surgery
- ❑ Line in place at discharge & location
- ❑ Foley in place at discharge & why
- ❑ Wounds—dressing type
- ❑ Antibiotic and discontinue date
- ❑ Special instructions

Provide Sepsis Fact Sheets:
- ❑ Patient and Family Education
- ❑ Patient Post-Discharge monitoring
- ❑ Patient Post-Discharge Action Plan
- ❑ Refer to Hand-Off Communication tool for staff

- ❑ Discharge summary faxed
- ❑ Medications and dosages updated
- ❑ Lab work needed

Follow-up appointments scheduled:
- ❑ Referral for home care agency
- ❑ Outpatient rehabilitation
- ❑ Support group meeting information
- ❑ Durable medical equipment order

Patient knows action plan for help:
- ❑ Who to call _____
- ❑ Where to go _____

MORE INFORMATION
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SEPSIS SURVIVORS ARE
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SEPSIS

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The Sepsis Fact Sheets are available on the HAP Resource Center as a downloadable PDF

https://haponlinecontent.azureedge.net/resourcelibrary/sepsis-fact-sheets-april-2021.pdf

Interactive Discussion: Speakers, Panelists, Attendees

Questions submitted at registration:

- Any recommended educational videos for nursing staff re: sepsis that covers identification, treatment, pathophysiology for RNs?
- Best practice tools to provide staff?
- Best practices for engaging **LTC leaders** in collaborating with hospitals?

Please Submit Additional Questions in Chat!

Tools & Resources

From Today's Speakers:

- Post-Discharge Sepsis Fact Sheet
- INTERACT Communication Tools- *create a free account for access*
- Seeing Sepsis Cards
- Facility Sepsis Algorithms

Additional Resources:

- HQIC Sepsis Change Path
- Sepsis Alliance Resources
- IPRO HQIC Resource Library

Key Takeaways

- Analyzing 30-day readmissions data to determine if sepsis is one of the leading causes is a key first step for your team.
- Preventing sepsis-related readmissions starts at admission with multidisciplinary teamwork and appropriate antibiotic stewardship.
- It is a misconception that collaboration takes too much time. In fact, collaborations with other facilities and with your QIN-QIO/HQIC provides resources that save you time!
- Collaborating is worth the investment. The key to success is through dialogue and active listening.
- Regardless of disposition, a solid plan for patient and family education, smooth transition, and thorough communication are key to a safe patient discharge.

Register for the Next HQIC Collaborative Event!

Save the Date!

Adverse Drug Events Webinar:

Exploring Hypoglycemic Solutions

Thursday, October 28th, 2021

12:00PM-1:00PM CT

Registration link coming soon

Thank you for Attending Today's Event

We value your input!

Please complete the brief survey posted in chat.

Contact Us

Alliant HQIC Team

Karen Holtz, MT (ASCP), MS, CPHQ
Alliant Quality
Karen.holtz@allianthealth.org

View our Website

IHC Team

Melissa Perry, MSW, LCSW
Hospital Quality Initiatives Project Coordinator
perrym@ihconline.org

View our Website

IPRO HQIC Team

Lynda Martin, MPA, BSN, RN, CPHQ
Senior Director, Patient Safety
martinl@qlarant.com
Rebecca Van Vorst, MSPH, CPHQ
HQIC Project Manager
RVanVorst@ipro.org

View our Website

Telligen HQIC Team

Meg Nugent, MHA, RN
HQIC Program Manager
mnugent@telligen.com

View our Website