KHC Hospital Improvement Innovation Network

January 31, 2018
10 to 11 a.m.

HIIN Goals:
By September 2018, hospitals in the KHC HIIN will achieve 20% reduction in all-cause harm and 12% reduction in readmissions.

Kansas Healthcare Collaborative

623 SW 10th Ave. • Topeka, KS 66612 • (785) 235-0763 • www.khconline.org

Agenda

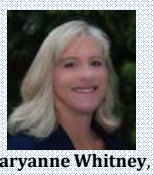
- Introductions and Announcements
- Measures & Data Update
- Sepsis & Readmissions
- Sepsis SNAP Update
- Upcoming Events

Introductions

Special Guests

Cynosure Health Improvement Advisors

Pat Teske, RN, MHA



Maryanne Whitney, RN, CNS, MSN

Betsy Lee, MSPH, BSN, RN

KHC Staff

Michele Clark
Program Director
mclark@khconline.org

Rob Rutherford
Senior Health Care Data Analyst
rrutherford@khconline.org

Special Guests
Hospital Quality and Patient Safety Leaders

Suzanne Fletcher, BSN, RN, CMSRN
Sepsis Coordinator
Wesley Medical Center, Wichita, KS
and
KHC HIIN Sepsis Improvement Advisor

Dorothy Rice, RN, BSN, MBA
Director of Quality, Trauma & Accreditation
Ransom Memorial Hospital
Ottawa, KS

Introducing SCRIPT UP

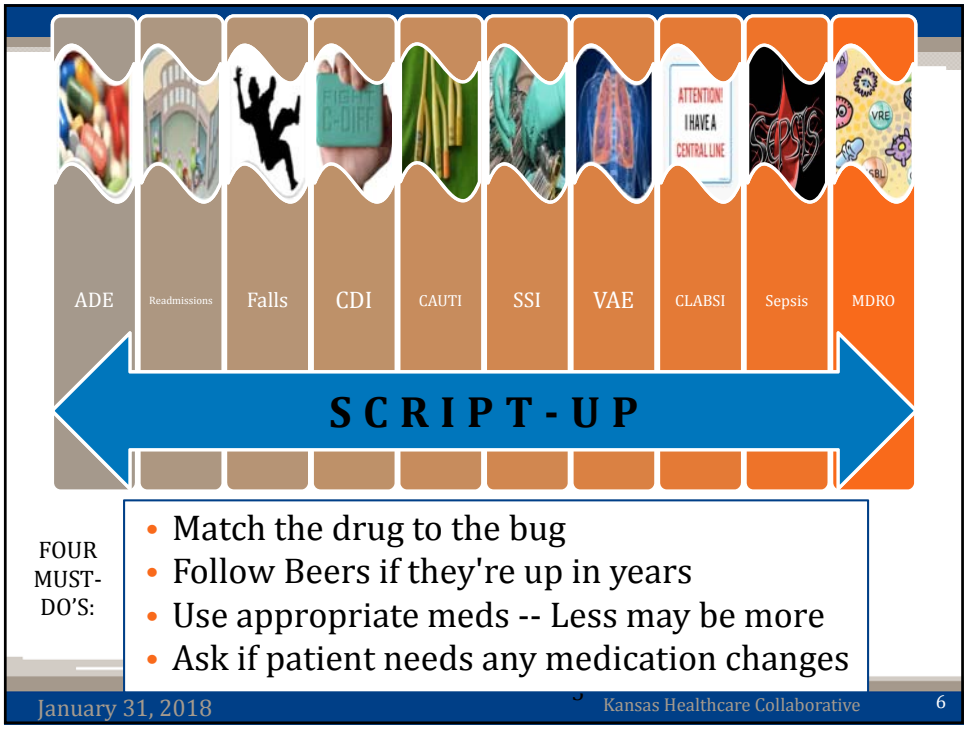
HRET HIIN

UP CAMPAIGN

A Fresh Approach to Harm Reduction

Foundational Questions

1. Is my patient awake enough to get up?
2. Have I protected my patient from infections?
3. Does my patient need any medication changes?


ADE
Readmissions
Falls
CDI
CAUTI
SSI
VAE
CLABSI
Sepsis
MDRO
ATTENTION! I HAVE A CENTRAL LINE
SCRIPT-UP
FOUR MUST-DO'S:
• Match the drug to the bug
• Follow Beers if they're up in years
• Use appropriate meds -- Less may be more
• Ask if patient needs any medication changes
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HRET HIIN Q.I. Fellowship
Session #2 begins at 11 am TODAY
2018 Quality Improvement Fellowship
► Two tracks with Institute for Healthcare faculty offer Q.I. training to kick-start and support projects related to the HIIN goals
► Offered from January to July 2018. Features interactive webinars and online courses on key topics in quality improvement. Simultaneous to the webinars and coursework, Fellows will apply their learning by either developing or advancing a project to improve outcomes in their own department or unit.
► Multiple Fellows are encouraged to participate from one organization. They may work as a team on a project, or individually.
Enroll by February 16
For more information, visit www.hret-hiin.org/fellowships/qifellowship/
Watch the informational webinar
www.hret-hiin.org/resources/display/hret-hiin-qi-fellowship-informational-call-1
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Summit on Quality
Call for Breakout Sessions and Poster Presentations

The Kansas Healthcare Collaborative and the Kansas Foundation for Medical Care, Inc. are now seeking applications for breakout sessions and poster presentations for the Summit on Quality to be held Friday, May 4, in Wichita.

The deadline for applications is Thursday, February 1.

Suggested topics include:

- Community/population health
- Creating and sustaining culture change in health care
- Engaging and inspiring leadership
- Innovative use of technology
- Patient and family engagement
- Practice transformation

https://www.khconline.org/files/Summit_on_Quality/2018/Breakout-Session-Instructions-and-Application.pdf

Measures & Data Update

- Milestone 6
- Overall HIIN Progress
- Focus Areas/Sprint

Rob Rutherford
Senior Health Care Data Analyst
Kansas Healthcare Collaborative
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(785) 235-0763 x1326

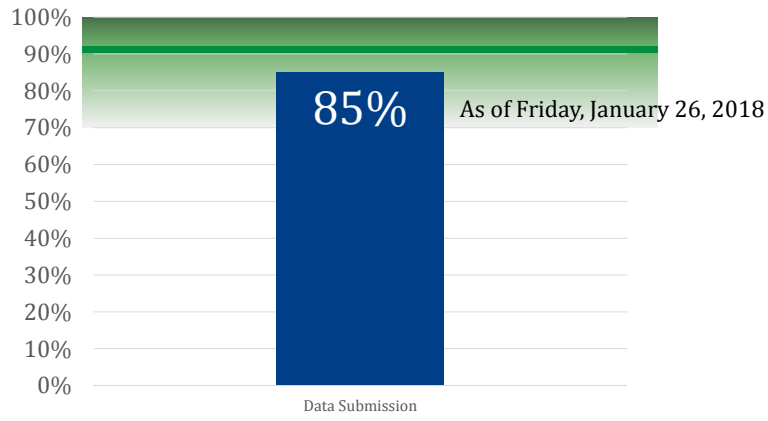
Milestone 6

- HRET HIIN Deadline January 31, 2018.
- Data Submission Oct. 2016 – Oct. 2017
  - *For at least 70% of applicable measures*

Milestone 6

KHC HIIN Data Submission

Oct. 2016 – Oct. 2017

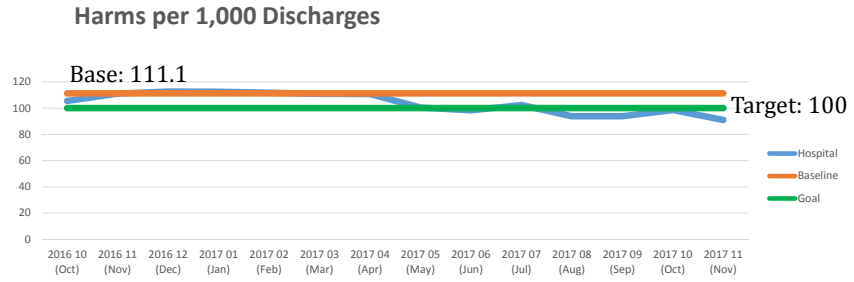


Monitoring Reports: Data Completion

KHC HIIN Evaluation Measures				Monitoring Months											
Area	Measure	Base-line Source	Baseline Rate	4Q2016			1Q2017			2Q2017			3Q2017			Oct. Nov.		Project Rate	20/12 Target Rate
ADE	Naloxone Administration	QHi	0.10	Y	Y	N	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	0.0	0.2
	Hypoglycemia in Inpatients Receiving Insulin	QHi	0.85	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	0.5	0.3
	Excessive Anticoagulation with Warfarin - Inpatients	QHi	8.22	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	1.6	4.2
CAUTI	CAUTI rate per 1,000 Catheter Days ICUs + Other Inpt. Units	NHSN	5.67	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	2.3	1.9
	CAUTI rate per 1,000 Catheter Days - ICUs	N/A																	
	Catheter Utilization Rate: ICUs + Other Units (excluding NICUs)	NHSN	55.0	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10.16	9.3
	Catheter Utilization Rate: ICUs excluding NICUs	N/A																	

Current KHC HIIN Progress

- Overall 10% Reduction in Harm!
- Saved 118 lives and $8,000,000!

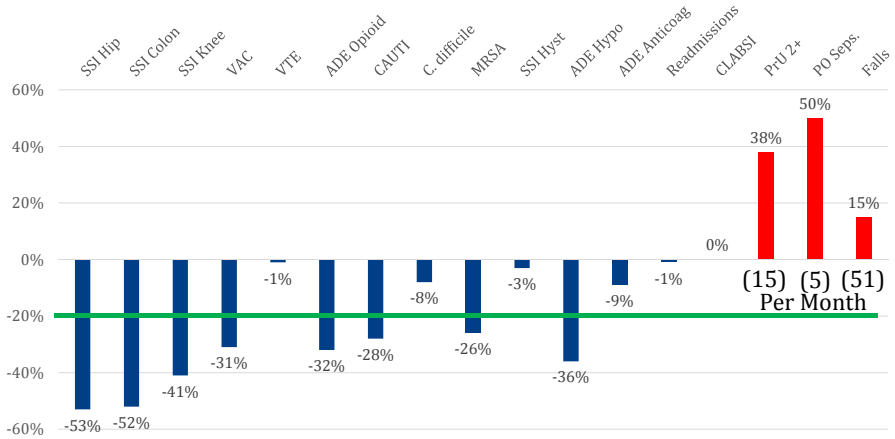


HRET HIIN Improvement Calculator v4.3 on 01/29/2018

Preliminary Results KHC HIIN Progress to date

Project-to-Date Improvement

Oct. 2016 through Dec. 2017



HRET HIIN Improvement Calculator v 4.3 on 01/29/2018

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Preliminary Results HIIN Progress to date

6 HRET HIIN Sprint Areas

HRET KHC HIIN Currently…

- **ADE: Hypoglycemia** (At Target)
- **CLABSI** (Prevent 2/Mo.)
- **CAUTI** (At Target)
- **CDI** (Prevent 11/Mo.)
- **Post-Op Sepsis** (Prevent 5/Mo.)
- **MRSA** (At Target)

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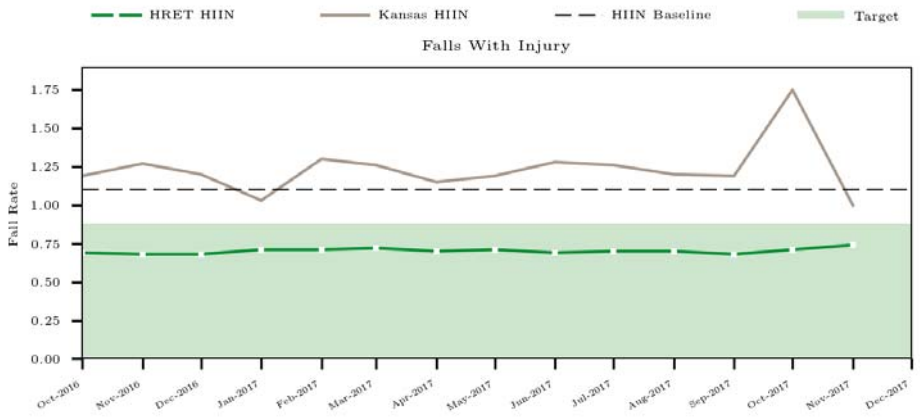
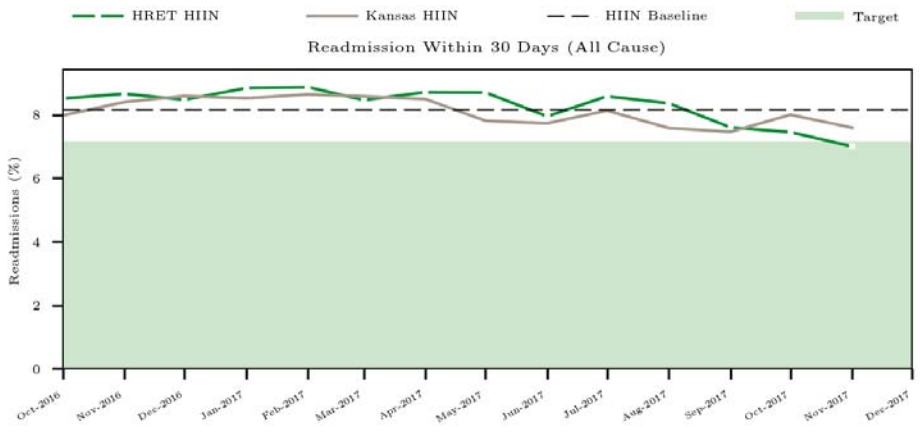
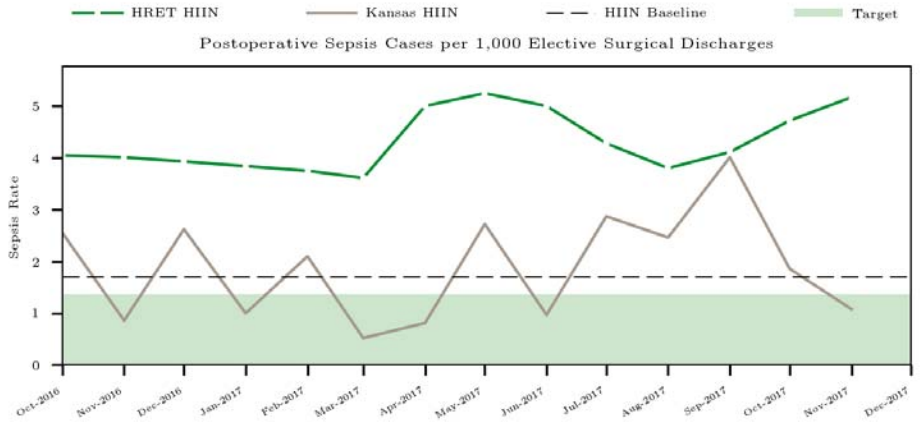
Falls with Injury (Prevent 51/Mo.)



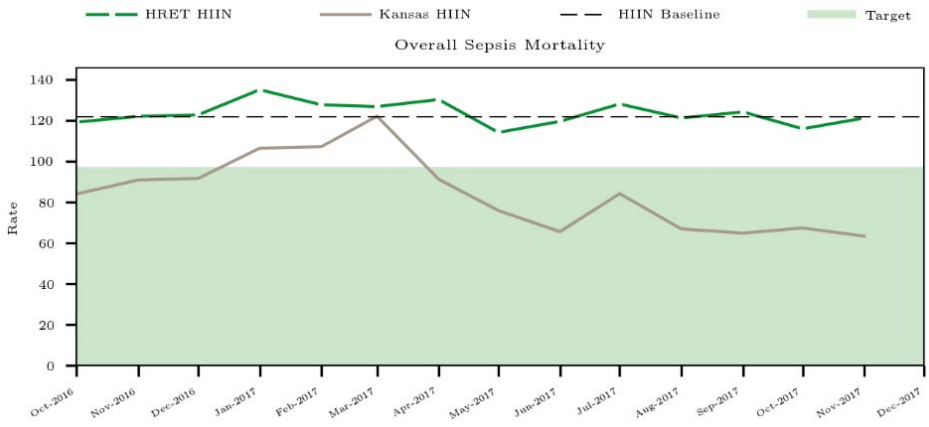
All-Cause Readmissions (Prevent 245/Mo.)



Post-Op Sepsis (Prevent 5/Mo.)



Overall Sepsis Mortality (At Target)



Kansas HIIN 2016-2017 Data Submission Schedule

Outcome & Process Measures for HACs occurring in:	Readmissions for index discharges in, and SSI for procedures performed in:	Submission Due
September, 2017	August, 2017	October 31, 2017
October, 2017	September, 2017	November 30, 2017
November, 2017	October, 2017	December 31, 2017
December, 2017	November, 2017	**January 31, 2018**
January, 2018	December, 2017	February 28, 2018
February, 2018	January, 2018	March 31, 2018
March, 2018	February, 2018	April 30, 2018
April, 2018	March, 2018	May 31, 2018
May, 2018	April, 2018	June 30, 2018
June, 2018	May, 2018	July 31, 2018

Reducing Sepsis Readmissions

Maryanne Whitney, RN, CNS, MSN
Pat Teske, RN, MHA

Why focus on sepsis?

Common

Costly

Sepsis readmissions are common

12% of all readmissions followed a sepsis hospitalization

	National Readmission Data[a]			Weighted Proportion of Cases in the United States	
	No. of All Index Admissions Readmitted Within 30 Days	Estimated Mean Length of Stay (95% CI), d[b]	Estimated Mean Cost per Readmission (95% CI), $[b]	Percentage of Index Admissions Readmitted Within 30 Days (95% CI)	Percentage of Total Estimated Cost of All Readmissions (95% CI)
Admissions associated with 30 d readmission	1 187 697	6.4 (6.4-6.5)	8242 (8225-8258)	NA	100.0
Primary Analyses[c]					
Sepsis	147 084	7.4 (7.3-7.4)	10 070 (10 021-10 119)	12.2 (11.9-12.4)	14.5 (14.2-14.8)
Acute myocardial infarction	15 001	5.7 (5.6-5.8)	9424 (9279-9571)	1.2 (1.2-1.3)	1.4 (1.3-1.5)
Heart failure	79 480	6.4 (6.4-6.5)	9051 (8990-9113)	6.7 (6.5-6.8)	7.5 (7.3-7.7)
Pneumonia	59 378	6.7 (6.6-6.7)	9533 (9466-9600)	5.2 (5.0-5.3)	5.5 (5.4-5.7)
Chronic obstructive pulmonary disease	54 396	6.0 (5.9-6.0)	8417 (8355-8480)	4.6 (4.5-4.8)	4.3 (4.1-4.4)

Mayr et al, JAMA 2017.

AHRQ statistical brief # 172

Medicare	Medicaid
CHF	Mood disorder
Sepsis	Schizophrenia
Pneumonia	Diabetes complications
COPD	Comp. of pregnancy
Arrhythmia	Alcohol-related
UTI	Early labor
Acute renal failure	**CHF**
AMI	**Sepsis**
Complication of device	**COPD**
Stroke	Substance-use related

Sepsis readmissions cost more

Sepsis readmissions cost more due to higher LOS

	National Readmission Data[a]			Weighted Proportion of Cases in the United States	
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Mayr et al, JAMA 2017.

More importantly

- Worse outcomes when readmitted
  - More ICU use
  - More hospice
  - More death
- 34% in skilled care facility after discharge
- Patients spend median of 10% of days alive after discharge living in acute facility

Jones et al, Annals ATS 2015; Prescott et al, Am J Resp Crit Care Med 2014.

Questions to ask?

Why are sepsis patients being readmitted?

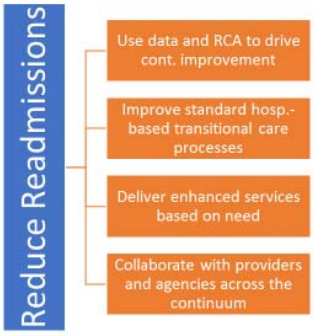
What will we do differently?

Polling question

Where is your organization in the sepsis readmission reduction journey?

- ❑ Not looking at sepsis readmissions yet.
- ❑ Just starting to look at sepsis readmissions.
- ❑ Testing specific strategies for reducing sepsis readmissions.
- ❑ Fully implemented approach for reducing sepsis readmissions.

Readmission reduction drivers



HRET HIIN Readmissions Change Package Driver Diagram
CP

Driver #1 - Data and root causes

Index admission = Sepsis

Index admission ≠ Sepsis

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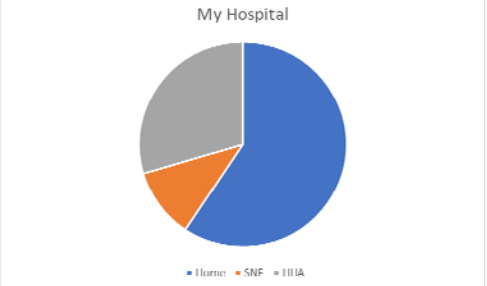
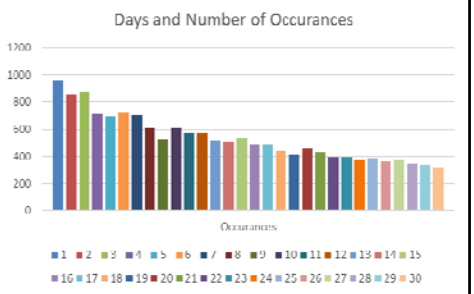
Data and root causes

What does the discharge disposition tell you?



How soon are your sepsis patients returning?



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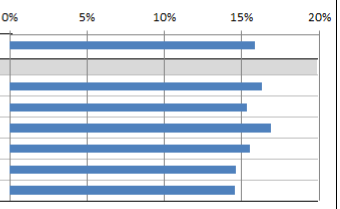
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network

Re-Admission Rate of KS Patients

having an Index Admission within Kansas

	Index Admission Count	Re-Admission Count	Re-Admission Rate
Kansas	100735	15952	16%
by Region			
Northwest	4508	735	16%
North Central	6478	991	15%
Northeast	47573	8029	17%
Southwest	3485	541	16%
South Central	33500	4901	15%
Southeast	5191	755	15%



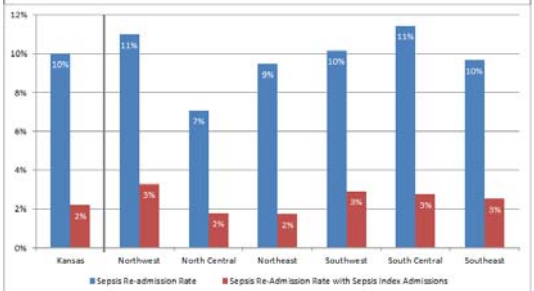
Notes:
Admissions and Re-Admission data was obtained from Medicare Part A claims showing an inpatient discharge date between and including April 1, 2016 to March 31, 2017 from a Short-Term Care Hospital, CAH, or Psychiatric Facility.
Re-Admission could occur anywhere.

This material was prepared by the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for Kansas, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-GPQIN-KS-GEN-177/0118

Sepsis Rate of In-State Re-Admissions for KS Patients

having an Index Admission anywhere

	All Re-Admissions Count	Sepsis Re-Admissions Count	Sepsis Re-Admissions Rate	Sepsis Re-Admissions with Sepsis Index Admissions Count	Sepsis Re-Admissions with Sepsis Index Admissions Rate
Kansas	15947	1597	10%	353	2%
by Region					
Northwest	729	80	11%	24	3%
North Central	1005	71	7%	18	2%
Northeast	8061	763	9%	142	2%
Southwest	552	56	10%	16	3%
South Central	4886	558	11%	135	3%
Southeast	714	69	10%	18	3%



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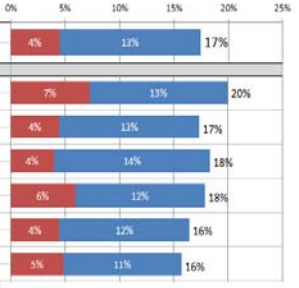
Sepsis Rate of In-State Admissions for KS Patients

having a Re-Admission anywhere

	Index Admissions	Index Admissions with a Sepsis DRG		Sepsis Index Admissions Resulting In Re-Admissions				
	Count	Count	Rate	Count	Rate	Re-Admission	Count	Rate
Kansas	100735	7858	8%	1374	17%	Shows Sepsis DRG	352	4%
						Without Sepsis DRG	1022	13%
By Region								
Northwest	4508	386	9%	77	20%	Shows Sepsis DRG	28	7%
						Without Sepsis DRG	49	13%
North Central	6478	380	6%	66	17%	Shows Sepsis DRG	17	4%
						Without Sepsis DRG	49	13%
Northeast	47573	3459	7%	634	18%	Shows Sepsis DRG	139	4%
						Without Sepsis DRG	495	14%
Southwest	3485	269	8%	48	18%	Shows Sepsis DRG	16	6%
						Without Sepsis DRG	32	12%
South Central	33500	2931	9%	481	16%	Shows Sepsis DRG	131	4%
						Without Sepsis DRG	350	12%
Southeast	5191	433	8%	68	16%	Shows Sepsis DRG	21	5%
						Without Sepsis DRG	47	11%



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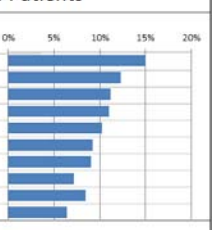
Days from Index Admission to Sepsis Re-Admission for Kansas Patients

Days	North West Kansas		North Central Kansas		North East Kansas		South West Kansas		South Central Kansas		South East Kansas		Overall	
1 - 3	11	14%	7	10%	120	16%	2	4%	92	16%	7	10%	239	15%
4 - 6	7	9%	5	7%	103	13%	8	14%	66	12%	7	10%	196	12%
7 - 9	7	9%	9	13%	83	11%	8	14%	64	11%	8	12%	179	11%
10 - 12	12	15%	8	11%	83	11%	4	7%	58	10%	11	16%	176	11%
13 - 15	7	9%	11	15%	77	10%	10	18%	52	9%	7	10%	164	10%
16 - 18	9	11%	3	4%	70	9%	7	13%	48	9%	10	14%	147	9%
19 - 21	9	11%	11	15%	70	9%	3	5%	45	8%	6	9%	144	9%
22 - 24	8	10%	4	6%	43	6%	6	11%	52	9%	2	3%	115	7%
25 - 27	8	10%	8	11%	60	8%	7	13%	44	8%	8	12%	135	8%
28 - 30	2	3%	5	7%	54	7%	1	2%	37	7%	3	4%	102	6%



Notes:
Sepsis Re-Admission's Index Admission was not limited to any particular area, but the Sepsis Re-Admission occurred within the identified area at the top of the table.
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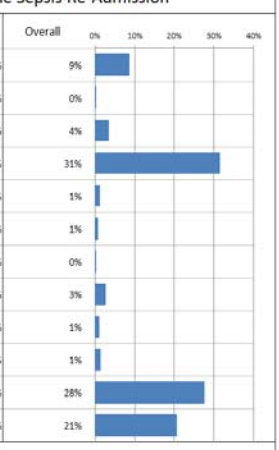
Kansas Patient's Most Recent Location Within 5 Days Prior To the Sepsis Re-Admission

	North West Kansas	North Central Kansas	North East Kansas	South West Kansas	South Central Kansas	South East Kansas	Overall
Critical Access Hospital	35%	23%	5%	14%	8%	7%	9%
Federally Qualified Health Centers	3%	1%	0%	0%	0%	0%	0%
Home Health Agencies	1%	1%	4%	4%	4%	0%	4%
At Home or Unknown	20%	28%	34%	48%	30%	22%	31%
Hospices	1%	0%	1%	0%	2%	0%	1%
Long-Term Care Hospitals	0%	0%	1%	0%	1%	0%	1%
Psychiatric Hospitals & Units	0%	0%	1%	0%	0%	0%	0%
Rehabilitation Hospitals & Units	0%	1%	3%	2%	3%	3%	3%
Renal Dialysis Facilities	1%	1%	1%	5%	1%	0%	1%
Rural Health Clinics	10%	4%	0%	5%	1%	1%	1%
Skilled Nursing Facilities	18%	28%	28%	13%	29%	36%	28%
Short-Term Care Hospitals	11%	11%	22%	9%	22%	30%	21%



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Admissions and Re-Admission data was obtained from Medicare Part A claims showing an inpatient discharge date between and including April 1, 2016 to March 31, 2017 from a Short-Term Care Hospital, CAH, or Psychiatric Facility.
No area limitations were placed on identification of patient's location prior to the Sepsis Re-Admission.

This material was prepared by the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for Kansas, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-GPQIN-KS-GEN-177/0118

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Risk factors for return

- Younger age
- Medicaid insurance, lower income, urban
- More comorbidities
  - Malignancy
  - Anemia
- Sepsis severity NOT an independent factor
- Conflicting data
  - Male gender, Black or Native American

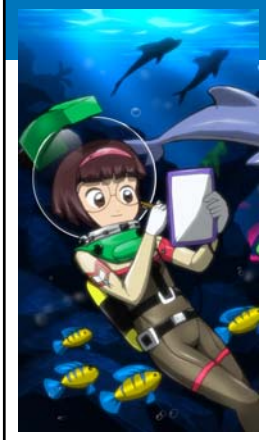
Chang et al, Crit Care Med, 2015; Jones et al, Annals ATS 2015.

Risk Factors for Return

- RBC transfusion, TPN and longer duration of antibiotics (main risk factors)
- Hospitalizations in prior year, length of stay
- **Study showed 50% of the readmissions – unresolved or recurrent infections**

Sun et al. Crit Care Med. 2016

What are your SEPSIS patients saying?



Take A Dive, Interview Five

- ❑ Identify 5 or more SEPSIS patients in the hospital that have been recently readmitted.
- ❑ Interview five SEPSIS patients/caregivers using the ASPIRE 2 tool.
- ❑ Aggregate interview results using the Readmission Case Review Analysis tool.
- ❑ Analyze responses for new insight regarding "why" SEPSIS patients soon returned to the hospital. What are the differences for your SEPSIS patients?

ASPIRE 2 Tool:
www.hret-hiin.org/resources/display/aspire-tool-2-readmission-review-tool

Readmissions Case Review Analysis Tool:
www.hret-hiin.org/resources/display/readmission-case-review-and-analysis

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Polling question

Where is your organization relative to sepsis readmission data?

- ❑ Have not performed any specific analysis of our sepsis readmissions data.
- ❑ Have analyzed our sepsis readmissions data but have not yet done sepsis readmission interviews.
- ❑ Have analyzed our sepsis readmissions data and done interviews.

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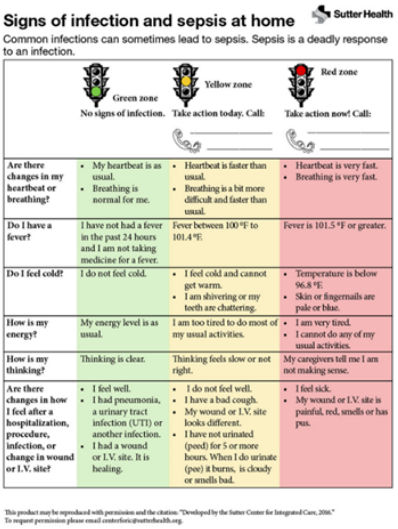
Driver #2 – Transitional care for all

- Whole person assessment
  - –Prior to discharge "think sepsis risk" for enhanced education:
    a. Indwelling catheters?
    b. Indwelling lines?
    c. Did pt develop a secondary infection during this admission? Pneumonia, CDI, wound infection, CLABSI, CAUTI?
    d. Does patient have a wound? Open? Closed?
    e. Is the pt currently being treated for an infection (on antibiotics)?
    f. Is there significant functional decline?

Then what?

- If so, consider:
  - Medication review in the construct of worsening chronic conditions
  - Decreased time to follow up
  - Specific sepsis education and disease recognition and management
  - Focus on the social, environmental, psychological aspects of sepsis



Signs of infection and sepsis at home Sutter Health

Common infections can sometimes lead to sepsis. Sepsis is a deadly response to an infection.

	Green zone No signs of infection.	Yellow zone Take action today. Call: _____	Red zone Take action now! Call: _____
Are there changes in my heartbeat or breathing?	• My heartbeat is as usual. • Breathing is normal for me.	• Heartbeat is faster than usual. • Breathing is a bit more difficult and faster than usual.	• Heartbeat is very fast. • Breathing is very fast.
Do I have a fever?	I have not had a fever in the past 24 hours and I am not taking medicine for a fever.	Fever between 100 °F to 101.4 °F.	Fever is 101.5 °F or greater.
Do I feel cold?	I do not feel cold.	• I feel cold and cannot get warm. • I am shivering or my teeth are chattering.	• Temperature is below 96.8 °F. • Skin or fingernails are pale or blue.
How is my energy?	My energy level is as usual.	I am too tired to do most of my usual activities.	• I am very tired. • I cannot do any of my usual activities.
How is my thinking?	Thinking is clear.	Thinking feels slow or not right.	My caregivers tell me I am not making sense.
Are there changes in how I feel after a hospitalization, procedure, infection, or change in wound or I.V. site?	• I feel well. • I had pneumonia, a urinary tract infection (UTI) or another infection. • I had a wound or I.V. site. It is healing.	• I do not feel well. • I have a bad cough. • My wound or I.V. site looks different. • I have not urinated (peed) for 5 or more hours. When I do urinate (poo) it burns, is cloudy or smells bad.	• I feel sick. • My wound or I.V. site is painful, red, smells or has pus.

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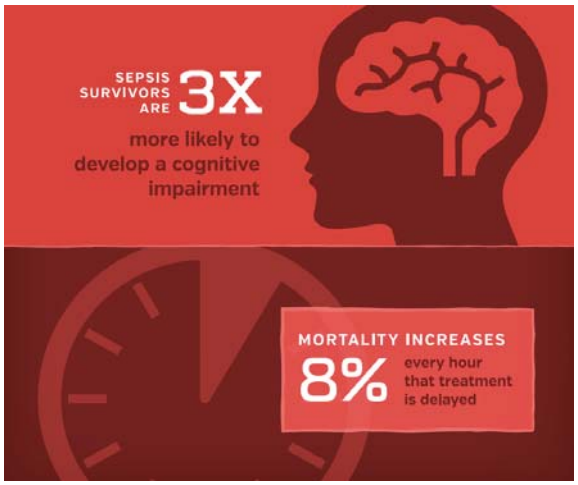
To request permission please email centerforic@sutterhealth.org.

Why educate?

- As many as 92% of all sepsis cases originate in the community
- Almost one-quarter of Americans believe that sepsis only happens in hospitals (23%)

Sepsis Alliance Awareness Survey 2017

Specific Post Sepsis Education



http://www.sepsis.org/files/SA_Infographic1_Square3_8.5x11_PrintReady.pdf

LIFE AFTER SEPSIS FACT SHEET

WHAT SEPSIS SURVIVORS NEED TO KNOW

Many survivors are left with **LIFE-CHANGING** *challenges.*

ABOUT SEPSIS

What is sepsis?

Sepsis is a complication caused by the body's overwhelming and life-threatening response to an infection, which can lead to tissue damage, organ failure, and death.

What causes sepsis?

Any type of infection that is anywhere in your body can cause sepsis. It is often associated with infections of the lungs (e.g., pneumonia), urinary tract (e.g., kidney), skin, and gut. An infection occurs when germs enter a person's body and multiply, causing illness and organ and tissue damage.

LIFE AFTER SEPSIS

What are the first steps in recovery?

After you have had sepsis, rehabilitation usually starts in the hospital by slowly helping you to move around and look after yourself: bathing, sitting up, standing, walking, taking yourself to the restroom, etc. The purpose of rehabilitation is to restore you back to your previous level of health or as close to it as possible. Begin your rehabilitation by building up your activities slowly, and rest when you are tired.

How will I feel when I get home?

You have been seriously ill, and your body and mind need time to get better. You may experience the following physical symptoms upon returning home:

- General to extreme weakness and fatigue
- Breathlessness
- General body pains or aches
- Difficulty moving around
- Difficulty sleeping
- Weight loss, lack of appetite, food not tasting normal
- Dry and itchy skin that may peel
- Brittle nails
- Hair loss

Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases

CS257671-D

https://www.cdc.gov/sepsis/pdfs/life-after-sepsis-fact-sheet.pdf

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It is also not unusual to have the following feelings once home:

- Unsure of yourself
- Not caring about your appearance
- Wanting to be alone, avoiding friends and family
- Flashbacks, bad memories
- Confusing reality (e.g., not sure what is real and what isn't)
- Feeling anxious, more worried than usual
- Poor concentration
- Depressed, angry, unmotivated
- Frustration at not being able to do everyday tasks

What can I do to help myself recover at home?

- Set small, achievable goals for yourself each week, such as taking a bath, dressing yourself, or walking up the stairs
- Rest and rebuild your strength
- Talk about what you are feeling to family and friends
- Record your thoughts, struggles, and milestones in a journal
- Learn about sepsis to understand what happened
- Ask your family to fill in any gaps you may have in your memory about what happened to you
- Eat a balanced diet
- Exercise if you feel up to it
- Make a list of questions to ask your healthcare provider when you go for a check up

Are there any long-term effects of sepsis?

Many people who survive sepsis recover completely and their lives return to normal. However, older people, people who have suffered more severe sepsis and those treated in an intensive care unit are at greatest risk of long-term problems, including suffering from post-sepsis syndrome.

What's normal and when should I be concerned?

Generally, the problems described in this fact sheet do improve with time. They are a normal response to what you have been through. Some hospitals have follow-up clinics or staff to help patients and families once they have been discharged. Find out if yours does or if there are local resources available to help you while you get better. However, if you feel that you are not getting better, or finding it difficult to cope, or continue to be exhausted call your healthcare provider.

Where can I get more information?

Sepsis Alliance (www.sepsis.org) was created to raise sepsis awareness among both the general public and healthcare professionals. Sepsis Alliance offers information on a variety of sepsis-related topics. To view the full series of Sepsis Information Guides, visit **sepsis.org/library**

https://www.cdc.gov/sepsis/pdfs/life-after-sepsis-fact-sheet.pdf

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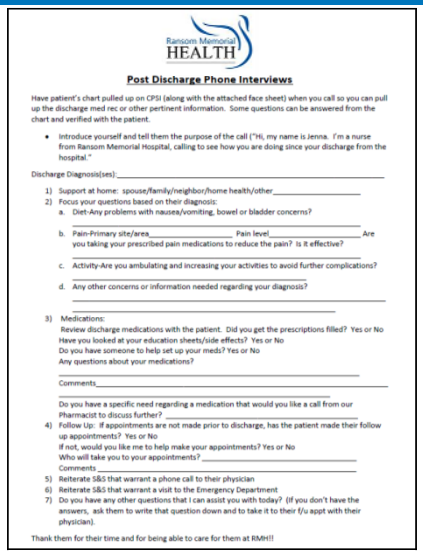
Stay close post discharge

"We have learned through our data analysis and PDCA cycles that we need to get our sepsis patients to a f/u appt within 48-72 hours.

We have also used the attachment here for our post discharge phone calls, which has been revised recently based on our analysis of our sepsis population as well as other post discharge phone calls.

We know we will still have changes as we move forth but we keep working to make it better for patients as we learn from our data and processes."

Thank you!
Dorothy Rice
Ransom Memorial Hospital, Ottawa, KS



Ransom Memorial HEALTH

Post Discharge Phone Interviews

Have patient's chart pulled up on CPSI (along with the attached face sheet) when you call so you can pull up the discharge med rec or other pertinent information. Some questions can be answered from the chart and verified with the patient.

- Introduce yourself and tell them the purpose of the call ("Hi, my name is Jenna. I'm a nurse from Ransom Memorial Hospital, calling to see how you are doing since your discharge from the hospital."

Discharge Diagnosis(ses):_____

1) Support at home: spouse/family/neighbor/home health/other_____
2) Focus your questions based on their diagnosis:
   a. Diet-Any problems with nausea/vomiting, bowel or bladder concerns?
   b. Pain-Primary site/area_____ Pain level_____ Are you taking your prescribed pain medications to reduce the pain? Is it effective?
   c. Activity-Are you ambulating and increasing your activities to avoid further complications?
   d. Any other concerns or information needed regarding your diagnosis?
3) Medications:
   Review discharge medications with the patient. Did you get the prescriptions filled? Yes or No
   Have you looked at your education sheets/side effects? Yes or No
   Do you have someone to help set up your meds? Yes or No
   Any questions about your medications?
   Comments_____
   Do you have a specific need regarding a medication that would you like a call from our Pharmacist to discuss further? _____
4) Follow Up: If appointments are not made prior to discharge, has the patient made their follow up appointments? Yes or No
   If not, would you like me to help make your appointments? Yes or No
   Who will take you to your appointments? _____
   Comments _____
5) Reiterate S&S that warrant a phone call to their physician
6) Reiterate S&S that warrant a visit to the Emergency Department
7) Do you have any other questions that I can assist you with today? (If you don't have the answers, ask them to write that question down and to take it to their f/u appt with their physician).

Thank them for their time and for being able to care for them at RMH!!

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Driver #3- Enhanced services

- Domains of problems among ICU survivors
  - Impairments in physical, cognitive, and psychological domains
  - Acceleration of chronic diseases
    - Cardiovascular disease
    - Myocardial infarction, Stroke, Atrial fibrillation
    - Chronic kidney disease
    - Dementia
    - Immunoparalysis/immunosenescence
      - Repeat episodes of infection & sepsis
  - High risk of death - ~1 in 2 or 1 in 3 likely to die at 1 year

Corrales et al., 2015 JAMA; Yende2014 AJRCCM; Walkeyet al., 2011 JAMA; Shah et al., 2013 AJRCCM Sun et al. Crit Care Med. 2016

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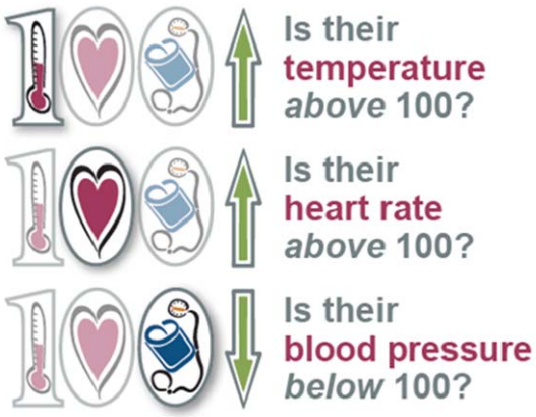
Complications in Sepsis

- Acute Kidney Injury
- Health Care Associated Infections
- Antibiotics
- Post Sepsis Syndrome
  - Weakness & balance
    - 50% of pts with sepsis in ICU
  - Cognitive
    - Thinking and memory
  - Mental Health
    - PTSD, Anxiety

What enhanced services are needed?

- Follow up care
- Support groups
- ???

Driver #4- Community collaboration



www.mnhospitals.org

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HRET

Who can you partner with?

- SNFs
- Home health
- Home providers (MDs, NPs)
- EMS
- Community groups
- Support groups

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Commitments

- What ideas did you like?
- What idea will you test in your organization?
- If you've already started, what's your next test?

LISTSERVs

- HRET HIIN Readmissions
- HRET HIIN Sepsis

HRET Sign Up
www.surveymonkey.com/r/S6C6KWN

- KHC HIIN Sepsis
  Contact amiller@khconline.org

HRET HIIN

Sepsis SNAP

Sepsis Transfers from
Rural/CAH to Tertiary Center

Focus: Sepsis Patients

Suzanne Fletcher
BSN, RN, CMSRN
Sepsis Coordinator
Wesley Healthcare
Quality and Infection Prevention

What is a SNAP?

- **S**afety **N**etwork to **A**ccelerate **P**erformance
- Voluntary learning networks
  - Approximately 10 hospital pairs
- Emerging best practices related to HIIN topics
- The 'next best practice' developed during a SNAP will be disseminated to all HRET HIIN hospitals.

Why Sepsis Transfer?

- Sepsis is one of the largest sources of preventable mortality for hospitalized patients.
- Current sepsis efforts in the HIIN focus on individual hospital performance yet there is a great opportunity to work upstream to better identify, treat and transfer septic or potentially septic patients who present to rural and critical access hospitals.
- Since mortality increases by 7.6% with every hour without broad spectrum antibiotics, a SNAP that focuses on improvement in these practices will benefit the entire HIIN to reach its goal of reducing sepsis mortality by 20% by September 2018.

SNAP Sepsis Transfer: Goals

- Implementation of an ideal transfer process in all participating hospital pairs resulting in a 20% reduction in sepsis mortality
- Learn the contextual components of implementation of ideal early identification, treatment, and transfer from rural/CAH to referral centers of patients with sepsis and septic shock so that these learnings can be used to accelerate implementation in other HIIN hospitals.
- Implementation of an ideal early identification, treatment, and transfer of septic and potentially septic patients in all participating hospital pairs.
- The group will develop an implementation guide to be used by HIIN hospitals to support them in their implementation of an ideal transfer.

Key elements of Sepsis Transfer

- Early identification of sepsis
  - rural/CAH settings
- Early treatment of sepsis
  - rural/CAH settings
  - Treat before you transfer
- Establish an ideal transfer process from rural/CAH to receiving facility
  - Communication, orders & feedback
- Collaborate with EMS providers

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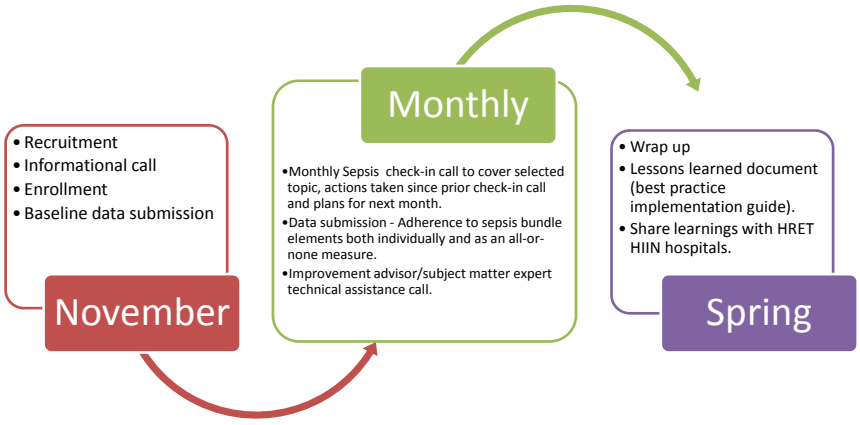
Timeframe



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Measurement Plan

Collect measures from participating hospitals:

1. Rural/CAH
   - Time of ED arrival to time of transfer
   - Time of ED arrival to time of sepsis screen
   - Compliance with sepsis screening
   - Treatment initiated and times for each; IV fluids, ABX, lactate, blood cultures per protocol

Measurement Plan

Collect measures from participating hospitals:

2. Receiving facility
   - Time of handoff to time of arrival at receiving facility
   - Sepsis mortality rate of patients identified with sepsis in the rural CAH setting
   - Timely Feedback to referring facility
   - Rate of sepsis identified after transfer

BASELINE DATA

- Nine groups of hospitals are enrolled in project
  - 7 are duets and 2 are triplets
  - Hospitals from IN, LA, MO, MS, NE, and TN

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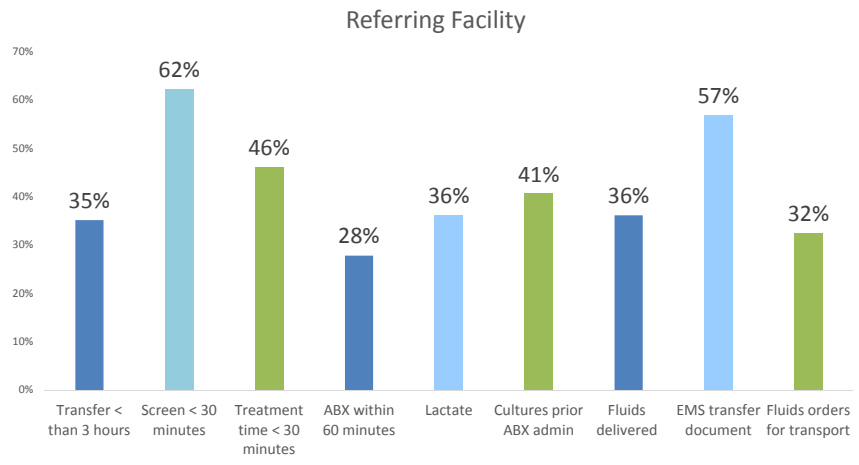
Baseline: Referring Hospitals



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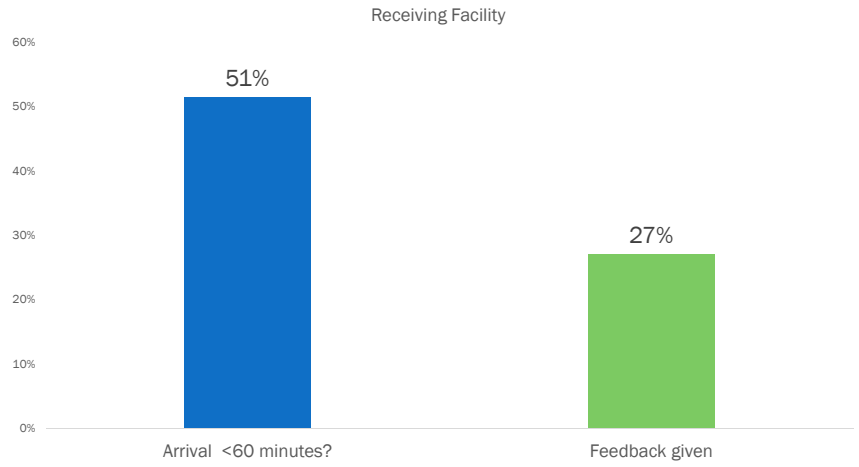
Baseline: Referring Hospital

Referring Hospital	BL	Nov	Dec	Jan	Feb
Number of patients screened for sepsis	995	0	0	0	0
Number of patients seen in ED	6,175	0	0	0	0

16%

Baseline: Receiving Hospital



Barriers Encountered

- Lack of resources
- Education
- Transportation challenges

Implementation Strategies

- Keys to success
  - Sharing of resources
  - Create and share education
  - Education and protocols for EMS
  - Communication between sending and receiving nurses
  - Communication between sending and receiving physician
  - Comprehensive hand-off tool
  - Feedback between hospitals-learning loops
  - Build relationships

Resources & Upcoming Events

- New Resources
- Upcoming Events
- Wrap Up

Michele Clark
Program Director
Kansas Healthcare Collaborative
mclark@khconline.org
(785) 235-0763 x1321

Enrollment Is Now Open!

All hospitals participating in the KHC HIIN are eligible to participate. Form is available in pod below.

2018
Kansas PFAC/PFA Collaborative

Cohort 4

Two Tracks Available

Regional Training Sessions
March 14 – Topeka
March 15 - Great Bend

Tiffany Christensen

VP for Experience Innovation

The Beryl Institute

Allison Chrestensen

Principal Patient & Family Engagement Consultant

Tandem Healthcare Soulutions

Goal:

To assist Kansas hospitals establish or build upon an active Patient and Family Advisory Council (PFAC) or engaging patient and family advisors (PFAs) to serve on a patient safety or quality improvement committee or team.

- ✓ National faculty
- ✓ Learning Sessions
- ✓ Coaching Calls
- ✓ Video Training Modules
- ✓ Online Toolkit
- ✓ ListServ®
- ✓ Private KHC web page
- ✓ Targeted site visits

Mark Your Calendars!

2018 Kansas HIIN Webinars

February 28, 2018
March 28, 2018
April 25, 2018
May 23, 2018

All webinars take place from 10:00 – 11:00 am CT
Register at www.khconline.org

Upcoming KHC Events

- Wound Assessment Workshop – Hays, KS
  February 8 - 9, 2018 1.5 days -- Starts at noon, Feb. 8.
- STRIVE Event– Wichita, KS *(for 21 participating hospitals)*
  March 7, 2018 Double Tree by Hilton Wichita Airport
- 2018 PFAC/PFE Collaborative Training (one day each)
  March 14 – 15, 2018 Topeka and Great Bend

Attn: Infection Preventionists

Kansas STRIVE Learning Event

March 7, 2018
DoubleTree by Hilton
Wichita Airport

Presented by KHC and HRET with partners KDHE and KFMC for the 21 Kansas hospitals participating in STRIVE

Save the Date

Infection Prevention Conference

March 8, 2018
DoubleTree by Hilton
Wichita Airport

More information will be available in January 2018.

Presented by:
Kansas Hospital Association

In cooperation with members of the:
Association for Professionals in Infection Control and Epidemiology
Wichita, Kansas City and Heart of America Chapters

AHRQ Safety Program for Improving Surgical Care and Recovery

A collaborative program to enhance the recovery of surgical patients

Collaborative program to enhance the recovery of surgical patients is funded and guided by AHRQ and conducted by the Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality in collaboration with the American College of Surgeons. There's no cost to participate.

To learn more, register for one of three one-hour webinars.

- **Feb. 1** at 2 pm CT,
- **Feb. 5** at 3 pm CT, or
- **Feb. 8** at 11 am CT

Contact iscr@facs.org for additional information.

https://qi.facs.org/iscr/Improving_Surgical_Care_and_Recovery__fact_sheet__FINAL.pdf

Recorded HRET HIIN Webinars

UP Campaign: WAKE UP | Managing Pain, Avoiding Oversedation

UP Campaign: GET UP | Early Mobility Matters

Culture of Safety: Building an Integrated Approach to Address Disruptive Behaviors

Falls: How to Implement the Fall TIPS© Tool

Physician Event: Portfolio Program (MOC IV) Overview

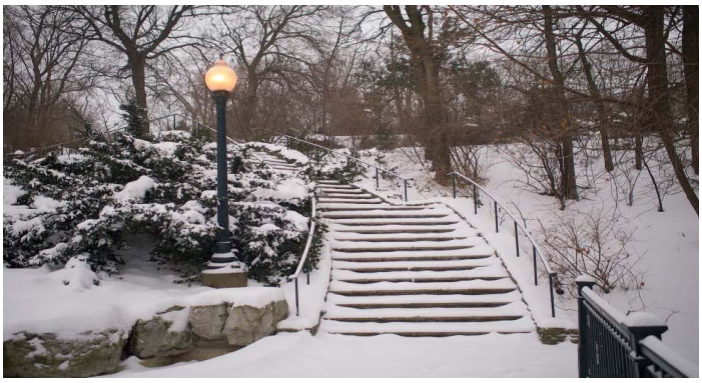
To watch past recordings, click here!
www.hret-hiin.org/events/past-events.shtml

Questions?

Contact your KHC Team

Please provide feedback to this webinar
Let us know your next steps.

https://www.surveymonkey.com/r/KHC-HIIN-013118



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