READMISSION PREVENTION FOR SEPSIS SURVIVORS

May 22, 2023

SEPSIS WEBSITE

ohiohospitals.org/sepsis

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Sepsis

Reducing Sepsis Mortality in Ohio Through Early Recognition, Appropriate Intervention

The OHA Board of Trustees identified reducing sepsis mortality in Ohio as one of the key focus areas for OHA and Ohio hospitals. Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure and death. In other words, it's your body's over active and toxic response to an infection. Sepsis impacted an estimated 41,000 Ohioans in 2017. Early recognition and treatment can reduce the morbidity and mortality of sepsis.

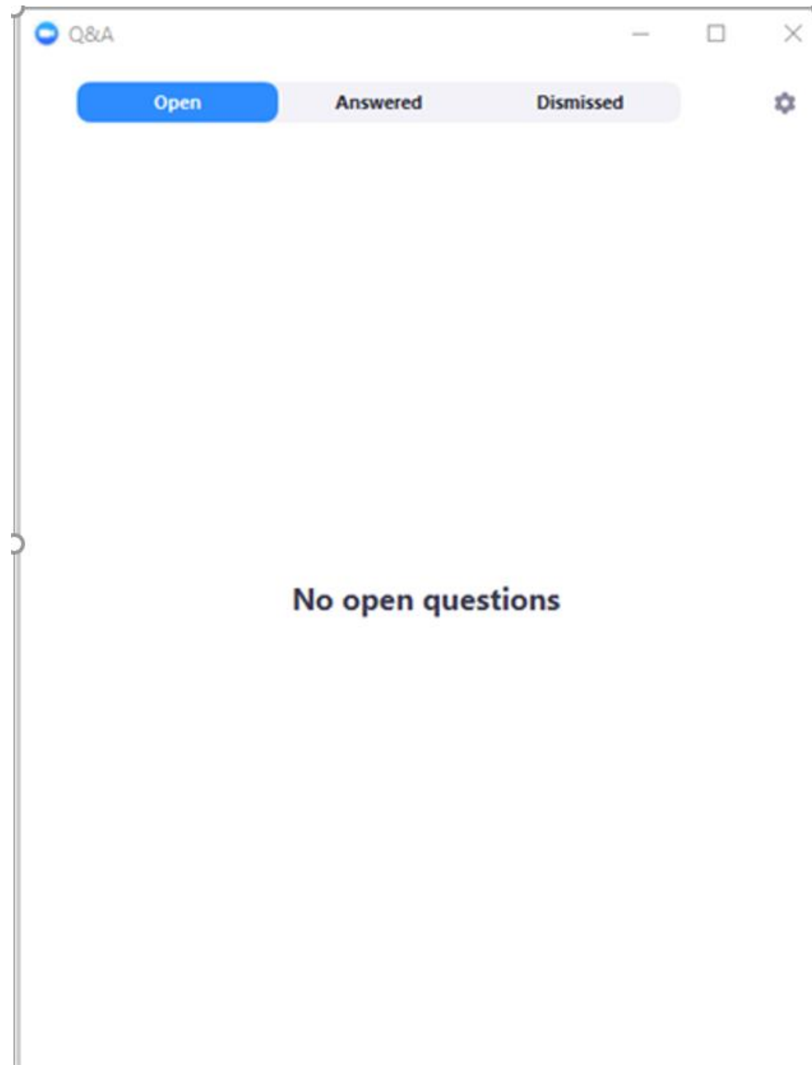
CONTINUING EDUCATION

- The link for the evaluation of today's program is: https://www.surveymonkey.com/r/Sepsis-July2023

- Please be sure to access the link, complete the evaluation form, and request your certificate. The evaluation process will remain open **two weeks** following the webcast. Your certificate will be emailed to you when the evaluation process closes after the 2-week process.

- If you have any questions, please contact Dorothy Frabott (Dorothy.Frabott@ohiohospitals.org)

SUBMITTING QUESTIONS



PRESENTER(S)

TRISH CRUZ, RN, MBA, BSN, PHN
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Sepsis Readmission Prevention

Trish Cruz, RN, MBA, BSN
Quality Advisor
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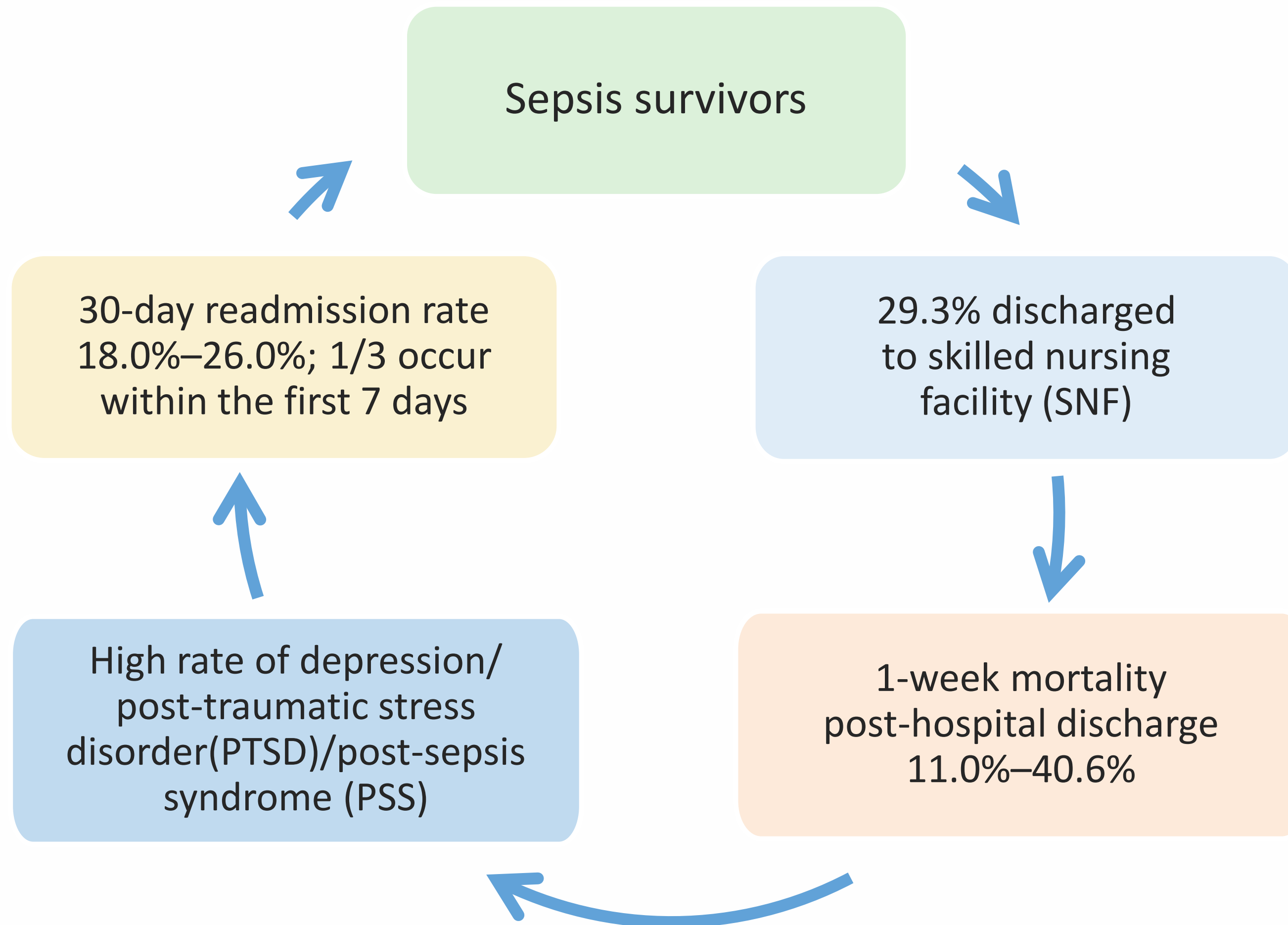
Sepsis Readmission Prevention

- More acute-care inpatients are surviving sepsis
  - At high risk for readmission
  - At higher risk of developing sepsis again
- Risk factors for readmission after sepsis:
  - Race, lower income, Medicare beneficiary, Medicaid beneficiary, younger than 80
  - Co-morbidities within the last year: malignancy, collagen vascular disease, chronic kidney disease, liver disease, chronic heart failure, chronic lung disease, diabetes, and hospitalization
- 1/3 of readmissions from sepsis survivors occur within the 1st week after discharge
- Strategies that can decrease readmissions of sepsis survivors:
  - Accurate medication reconciliation
  - Early and enhanced follow-up with primary care provider (PCP) who has access to the discharge summary
  - Early rehabilitation

HSAG HQIC Newsletter April 2023. conta.cc/3JpbB7v
Goodwin AJ. Readmissions among sepsis survivors. Clin Pulm Med. (2018). www.ncbi.nlm.nih.gov/pmc/articles/PMC6141202
Lee JT. Trends in post-acute care use after admissions for sepsis. Ann Am Thorac Soc. (2020). www.ncbi.nlm.nih.gov/pmc/articles/PMC6944346
CDC. I Survived Sepsis. What's Next? (2022). www.cdc.gov/sepsis/life-after-sepsis/index.html#:~:text=Nightmares

Surviving Sepsis



Goodwin AJ, and Ford DW. Readmissions among sepsis survivors: Risk factors and prevention. Clin Pulm Med 2018. www.ncbi.nlm.nih.gov/pmc/articles/PMC6141202
Lee JT, et al. Trends post-acute care use after admissions for sepsis. Ann Am Thorac Soc 2020. www.ncbi.nlm.nih.gov/pmc/articles/PMC6944346/#:~:text=Of%201%2C640%2C433%20hospital%20discharges%20after,%2C%20and%202.5%25%20to%20IRFs.
Sepsis Alliance. www.sepsis.org/sepsis-basics/post-sepsis-syndrome

OBJECTIVES

- Review PSS.
- Explore health equity in sepsis care.
- Identify end-of-life resources.
- Discuss sepsis prevention strategies.
- Summarize sepsis readmission prevention tools, resources, and best practices.

PSS

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PSS Symptoms

Physical

- Insomnia, difficulty getting to sleep or staying asleep
- Disabling muscle and joint pain
- Fatigue, lethargy
- Shortness of breath (SOB)
- Swelling of limbs
- Repeat infections
- Poor appetite
- Hair loss
- Skin rash
- Reduced organ function (kidney, liver, heart)

Psychological

- Nightmare, vivid hallucinations, and panic attacks
- Flashbacks
- Poor concentration
- Decreased mental (cognitive) function
- Loss of self-esteem and self-belief
- Depression
- Mood swings
- Memory loss
- PTSD

Sepsis Alliance. Post-Sepsis Syndrome—PSS. www.sepsis.org/life-after-sepsis/post-sepsis-syndrome

PSS Treatment

- Emotional and psychological support
  - Counseling
  - Cognitive behavioral therapy
  - Neuropsychiatric assessment
- Physical support
  - Physical therapy
  - Neurological rehabilitation

Sepsis Alliance. Post-Sepsis Syndrome—PSS. www.sepsis.org/life-after-sepsis/post-sepsis-syndrome

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PSS Situation, Background, Assessment, Recommendation (SBAR)

Situation: Resident/patient has symptoms of PSS.
Background: A large percentage of sepsis survivors and their families experience PSS symptoms.
Assessment: The patient is experiencing the following symptoms:

Physical
- ❑ Insomnia, difficulty getting to sleep or staying asleep
- ❑ Disabling muscle and joint pain
- ❑ Fatigue, lethargy
- ❑ SOB
- ❑ Swelling of limbs
- ❑ Repeat infections
- ❑ Poor appetite
- ❑ Hair loss
- ❑ Skin rash
- ❑ Reduced organ function (kidney, liver, heart)

Psychological
- ❑ Nightmare, vivid hallucinations, and panic attacks
- ❑ Flashbacks
- ❑ Poor concentration
- ❑ Decreased mental (cognitive) function
- ❑ Loss of self-esteem and self-belief
- ❑ Depression
- ❑ Mood swings
- ❑ Memory loss
- ❑ PTSD

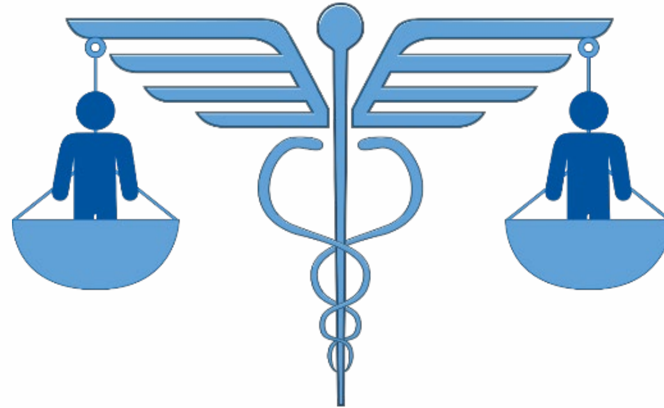
Recommendation: "I think this patient has PSS. Please consider a referral/consult for counseling or physical therapy."

Sepsis Alliance Letter to Doctor. (scroll to bottom) www.sepsis.org/sepsis-basics/post-sepsis-syndrome

PSS Interventions

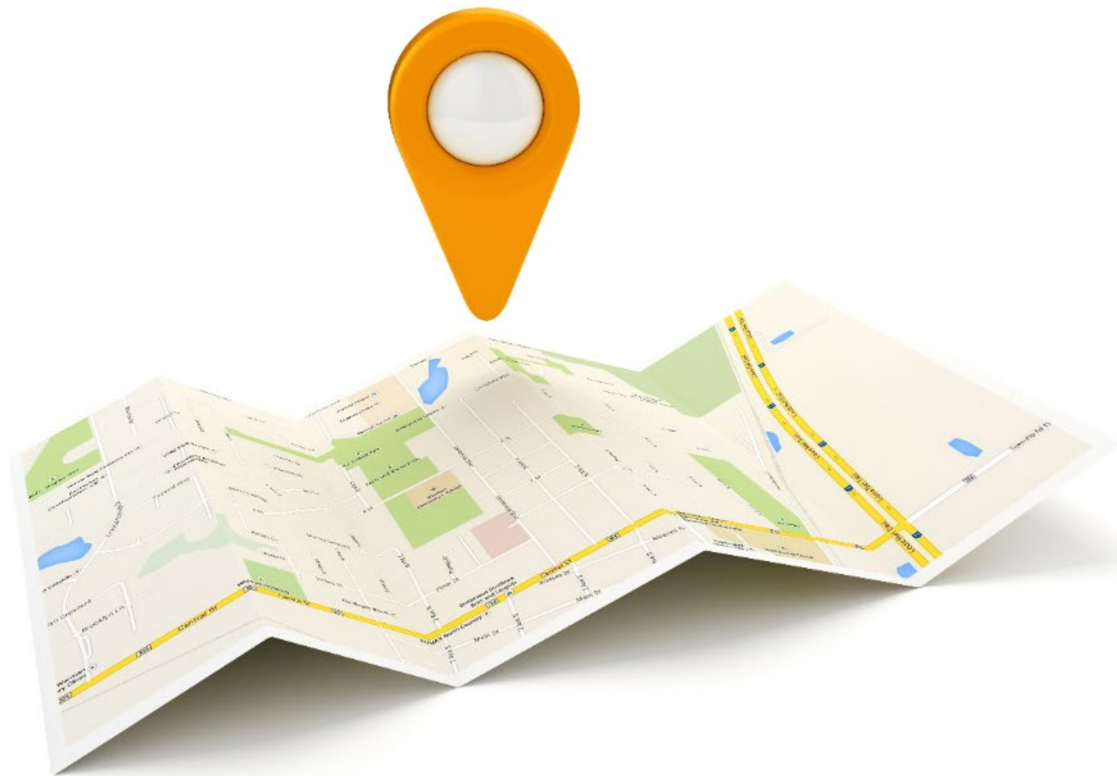
- Understand the potential for PSS.
  - Communicate with the provider.
  - Sometimes letting your patient know he or she is not alone helps healing.
  - Provide an opportunity for your patient to talk.

The Impact of Health Equity



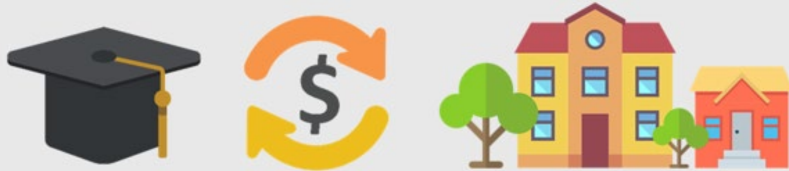
Greatest Predictor of Life Expectancy

Your **ZIP Code**



www.cdc.gov/nchs/data-visualization/life-expectancy/index.html

Social Determinants as a Healthcare Driver

SDOH	Healthcare
	

80% to 90% of health outcome contributors are SDOH.

—National Academy of Medicine

SDOH = Social Determinants of Health

nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five

SDOH Impact

1 in 10 Americans live in poverty with the inability to afford healthcare, healthy food, and housing.[1]

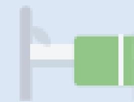
Dual-Eligible Patients

(Patients on Medicare and Medicaid)[2]

1.5 times higher hospital utilization

70% higher prescribing of "high-risk" drugs

Anticoagulants, glycemic agents, opioids



18% higher avoidable readmissions

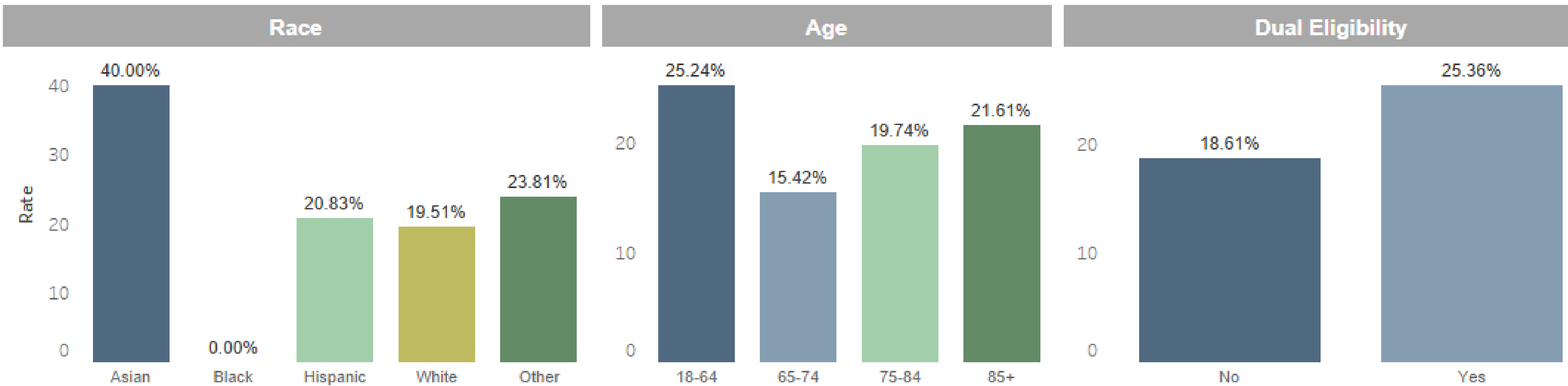
1. health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability
2. Heath, S. Health Payer Intelligence xtelligent Healthcare Media. 2019. healthpayerintelligence.com/news/most-medicare-dual-eligibles-see-social-determinants-of-health

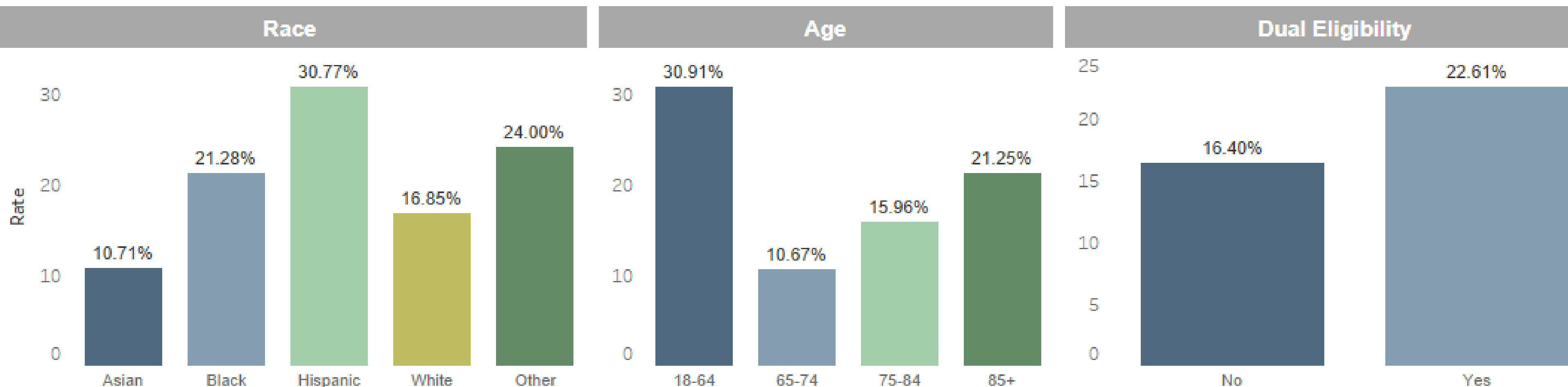
Populations Experiencing Disparities

- Racial and ethnic minority groups
- Persons with disabilities
- Women
- LGBTQI +
- Persons with limited English proficiency
- Rural populations

www.cdc.gov/healthequity/whatis/index.html

SDOH Examples:
Patients With Medicare Fee-for-Service





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Why Collect REaL Data? (Race, Ethnicity, and Language)

Frequently Asked Questions

About the Collection of Patient Race, Ethnicity, and Language Information

Q: What if I don't want to answer these questions?
A: It is perfectly alright if you do not want to answer these questions. We will provide you care no matter how you choose to answer. However, knowing the answers to these questions helps our hospital provide more personalized care.

Q: What do my race and ethnicity have to do with my health?
A: Your race and ethnic backgrounds may place you at different risks for some diseases. By knowing more about you, the hospital will be better able to meet your health needs.

Q: Who are you collecting this information from?
A: This hospital collects this information from all patients.

Q: Why am I being asked these questions?
A: This hospital collects information on race, ethnic backgrounds, and the language you speak from all our patients to make sure that everyone receives personalized care. By knowing more about you, we will be better able to meet your health needs.

Q: What will my information be used for at the hospital?
A: Your answers to these questions can help us to offer more personalized services and programs to you and others like you. Hospitals can also use your answers to make sure that all patients are getting the same quality of care no matter their race or ethnicity.

Q: Who will see my information?
A: Your information will be kept private and safe. The only people who will see your race and ethnicity information are members of your care team.

Q: What if I belong to more than one race?
A: You can check off all the races you belong to.

Q: What if I don't know my race or ethnicity?
A: If you don't know your race or ethnicity, you can talk to hospital registration staff and they can help you decide the best way to answer.

Q: Who can I ask questions about this?
A: The hospital registration staff and their supervisors are happy to answer any questions you may have.

This material was prepared by Health Services Advisory Group (HSAG), a Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an a gency of the U.S. Department of Health and Human Services (HHS). Views expressed in this document 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 No. XS-HQIC-DIS-06242021-01

Preguntas Frecuentes

Acerca de la recopilación de información sobre la raza, el origen étnico y el idioma del paciente

P. ¿Qué sucede si no quiero responder a estas preguntas?
R: No hay ningún problema si no desea responder a estas preguntas. Le brindaremos atención independientemente de cómo elija responder. Sin embargo, saber las respuestas a estas preguntas permite que nuestro hospital ofrezca una atención más personalizada.

P: ¿Qué relación tienen mi raza y mi origen étnico con mi salud?
R: Su raza y su procedencia étnica podrían generarle diferentes riesgos para algunas enfermedades. Al saber más sobre usted, el hospital podrá satisfacer mejor sus necesidades médicas.

P: ¿De quiénes obtienen esta información?
R: Este hospital obtiene esta información de todos los pacientes.

P: ¿Por qué me hacen estas preguntas?
R: Este hospital recopila información sobre la raza, la procedencia étnica y el idioma que hablan todos nues pacientes, a fin de asegurarnos de que todas las personas reciban atención personalizada. Al saber más s usted, podremos satisfacer mejor sus necesidades médicas.

P: ¿Para qué se utilizará mi información en el hospital?
R: Sus respuestas a estas preguntas pueden ayudarnos a ofrecer más servicios y programas personaliz usted y otras personas como usted. Los hospitales también pueden usar sus respuestas para cerciorar todos los pacientes reciban la misma calidad de atención, más allá de su raza u origen étnico.

P: ¿Quién verá mi información?
R: Se preservará la privacidad y la seguridad de su información. Las únicas personas que verán la información sobre su raza y origen étnico son los miembros de su equipo de atención.

P: ¿Qué sucede si pertenezco a más de una raza?
R: Puede marcar todas las razas a las que pertenezca.

P: ¿Qué sucede si no sé a qué raza u origen étnico pertenezco?
R: Si no sabe cuál es su raza o su origen étnico, puede hablar con el personal de registro del hospital y ellos podrán ayudarle a decidir la mejor manera de responder.

P: ¿A quién puedo hacerle preguntas sobre este tema?
R: El personal de registro del hospital y sus supervisores con gusto responderán a cualquier pregunta que pueda tener.

Este material ha sido preparado por el Grupo de Asesoramiento en Servicios de Salud (HSAG, por sus siglas en inglés), un Contratista de Mejora de la Calidad Hospitalaria (HQIC, por sus siglas en inglés) bajo contrato con los Centros de Servicios de Medicare y Medicaid (CMS, por sus siglas en inglés), una agencia del Departamento de Salud y Servicios Humanos (HHS, por sus siglas en inglés) de los Estados Unidos. Las opiniones expresadas en este documento no reflejan necesariamente las opiniones oficiales ni la política de los CMS o el HHS, y toda referencia a un producto o entidad específicos en el presente no constituye un aval de dicho producto o entidad por parte de los CMS o del HHS. Publicación n.º. XS-HQIC-DIS-01072022-01

www.hsag.com/globalassets/hqic/hqic-ptedwhycollectrealdata.pdf
www.hsag.com/contentassets/5d9c4e7840fe40fcac82ffb3e2a1eb6e/hqic-ptedwhycollectrealldata_spanish.pdf

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End of Life

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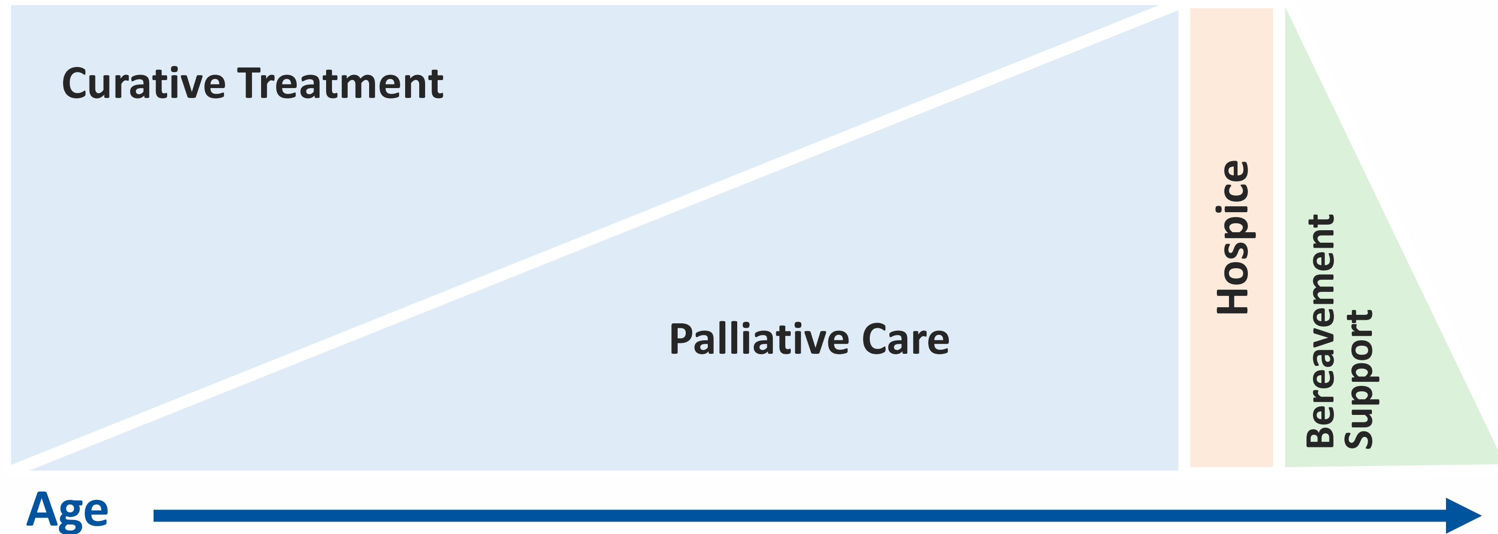
Healthcare Throughout Life



- Does your patient have an advance directive?
- Wish, worry, wonder.

NIH. Hospice Benefits. www.ncbi.nlm.nih.gov/books/NBK554501
Five Wishes: www.fivewishes.org

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Goals Clarification

Goals Clarification for Patients	
• What is the minimum quality of life you are willing to live with? • What is the maximum burden you are willing to go through to achieve your minimum quality of life?	
Goals Clarification for Families	
• Is this what your loved one said they wanted? • Is this what you think your loved one would want? • Is this what you want for your loved one?	
Goals Clarification for Physicians	
Life Expectancy With Care	**Life Expectancy Without Care**
❑ Hours to days ❑ Days to weeks ❑ Weeks to months ❑ Longer	❑ Hours to days ❑ Days to weeks ❑ Weeks to months ❑ Longer

HSAG Sepsis Mortality Toolkit. www.hsag.com/globalassets/hqic/hsaghqic_sepsismortalitytoolkit.pdf

Triggers for Goals Clarification

Examples of Non-Critical Care Triggers
Presence of serious illness *and* one or more of the following:
1. New diagnosis of life-limiting illness for symptom control.
2. Progressive metastatic cancer.
3. Multiple hospitalizations or illness within the last 3 months.
4. Difficult to control physical or emotional symptoms such as pain, dyspnea, nausea, etc.
5. Conflicts regarding the use of non-oral feeding or hydration in cognitively impaired, seriously ill, or dying patient.
6. LACE score ≥ 15.
If the patient has any of the above triggers, consider a patient/family conference for goals clarification.

Examples of Critical Care Triggers
Presence of serious illness *and* one or more of the following:
1. Admission in the setting of one or more chronic life-limiting conditions (i.e., advanced dementia as evidenced by non-independent ADLs, recurrent aspiration pneumonia, non-healing stage 3–4 pressure injuries).
2. Two or more ICU admissions within the same hospitalization.
3. Failed or prolonged attempt to wean from the ventilator.
4. Multi-organ failure.
5. Consideration of ventilator withdrawal with expected death.
6. Advanced metastatic cancer with poor functional status.
7. Consideration of patient transfer to a long-term ventilator facility.
8. Healthcare provider/family miscommunication or conflict.
9. LACE score ≥ 15.
If the patient has any of the above triggers, consider a patient/family conference for goals clarification.

LACE = length of stay, acuity, comorbidities, emergency room   ADLs = activities of daily living   ICU = intensive care unit

HSAG Sepsis Mortality Toolkit. www.hsag.com/globalassets/hqic/hsaghqic_sepsismortalitytoolkit.pdf

Sepsis Prevention

If you prevent infection, then you cannot get sepsis.

Common Sources

- Respiratory
- Urinary tract
- Gut
- Skin

CDC. Making Health Care Safer. www.cdc.gov/vitalsigns/sepsis/index.html

Sepsis Prevention

If you prevent infection, then you cannot get sepsis

- Perform hand hygiene.
  - Ensure patient can wash hands before eating, after toileting, and after coughing or sneezing. (This may mean keeping hand sanitizer or wipes at the bedside.)
- Stay up-to-date with vaccines.
  - Flu, COVID-19, chicken pox, shingles, pneumonia, tetanus, etc.
- Avoid Foleys and central lines as much as possible.
- Provide proper wound care.
  - Wash hands before touching an open wound (use clean gloves if possible).
  - Follow doctors' orders regarding wound care.
  - Watch for signs and symptoms of infection: redness, warmth, increased pain, and/or discharge from wound.
  - Do not pop blisters.
- Encourage mobility.
  - Ensure adequate pain control.
  - Promote ambulation.
- Maintain oral care.

Sepsis Alliance Sepsis Prevention. www.sepsis.org/sepsis-basics/prevention
CDC. Infection Control Assessment. www.cdc.gov/infectioncontrol/pdf/icar/ltcf.pdf

Pledge for Clean Hands

To Help Keep Each Other Safe

As a patient of this facility it is okay for me to speak up for clean hands.

Washing your hands for at least 20 seconds is the most effective way to prevent the spread of diseases like the flu, cold, and COVID-19.

When should I wash my hands?

Before:
- Touching your eyes, nose, or mouth
- Leaving the bathroom

Before and after:
- Eating
- Leaving your room

After:
- Blowing your nose, coughing, or sneezing
- Touching common surfaces and objects such as bed rails, remote controls, or the phone
- Touching garbage

When should I ask others to wash their hands?

Before:
- Entering and leaving the room
- Leaving the bathroom

Before and after:
- Your team provides personal care such as treating a cut or wound
- Receiving medications
- Handling equipment
- Close contact with others

After:
- They blow their nose, cough, or sneeze

Your healthcare team supports this effort and cares about your health. Speak up and remind us to keep our pledge for clean hands.

Compromiso de lavado de manos

para mantenernos todos a salvo

Como paciente de este centro, puedo hablar a favor del lavado de manos.

Lavarse las manos durante por lo menos 20 segundos es la manera más eficaz de prevenir la propagación de enfermedades como la gripe, el resfrío y la COVID-19.

¿Cuándo debería lavarme las manos?

Antes de:
- Tocarse los ojos, la nariz o la boca
- Salir del baño

Antes y después de:
- Comer
- Salir de su habitación

Después de:
- Sonarse la nariz, toser o estornudar
- Tocar superficies y objetos comunes, como barandillas de camas, controles remotos o el teléfono
- Tocar basura

¿Cuándo debería pedirle a otras personas que se laven las manos?

Antes de:
- Entrar y salir habitación
- Salir del baño

Antes y desp
- Que su equip atención person durante el tratam una cortadura o
- Recibir medicam
- Manipular equip
- Un contacto es otras personas

Después de:
- Que ellos se suenen la nariz, tosan o estornuden

Su equipo de atención médica apoya esta iniciativa y se preocupa por su salud. Diga lo que piensa y recuérdenos nuestro compromiso de lavado de manos.

www.hsag.com/globalassets/hqic/hqic_cleanhandspledge.pdf
www.hsag.com/globalassets/hqic/hqic_cleanhandspledge_sp.pdf

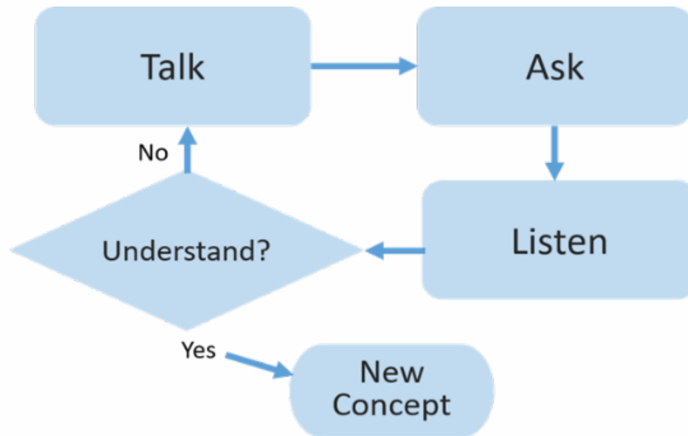
Sepsis Readmission Prevention

Readmission Prevention Interventions

- Ensure medication reconciliation, on admission and at discharge, is accurate.
- Assist with scheduling the follow-up PCP appointment.
- Make sure the discharge summary tells a story **and** is made available to the next provider of care.
- Engage patients and families in care at the level they choose, where possible.
- Provide a phone number to patients for questions that arise after discharge, but before the first clinic or doctor appointment.
- Use teach-back.
- If patients are at end of life, then discuss this with them and provide resources, such as hospice.
- Discharge to the appropriate level of care.
- Use a discharge planning checklist.

Goodwin AJ, et al. Readmissions among sepsis survivors: Risk factors and prevention. Clin Pulm Med. (2018).
www.ncbi.nlm.nih.gov/pmc/articles/PMC6141202

Teach-Back



- A way to make sure you explained information clearly.
- Not a quiz for patients.
- A way to check for patient, family, and care partner understanding.
- Evidence-based health literacy intervention that improves patient-provider communication and patient health outcomes.

American Medical Association (AMA). Health Literacy Video. www.youtube.com/watch?v=BgTuD7I7LG8
Schillinger 2003. jamanetwork.com/journals/jamainternalmedicine/article-abstract/214905
Teach Back Training. www.hsag.com/en/medicare-providers/care-coordination/teach-back

HSAG Teach-Back Resources

Form	Purpose	Rationale	Page
Practice Using Plain Language	This tool asks staff members to identify medical jargon commonly used and translate those terms into plain language.	Patients often do not comprehend common medical jargon. Translating these elements to plain language aids in comprehension and compliance of material.	5.1
Teach-Back Sentence Starters	This document is used by staff members as they become familiar with using the teach- back strategy.	Incorporating questions into plain language may be difficult for staff. Practicing this strategy will help hardwire the delivery.	5.2
Teach-back Flyers for Self-Training	To provide staff members with an overview of the importance of teach-back and connect them with teach-back resources.	Staff are often aware of teach-back but forget to implement it. These resources can help staff develop the habit of using teach-back in everyday practice.	5.3
Reminder to Use Teach-Back Posters	To provide staff with reminders to always use teach-back.	Teach-back is changing the way providers check for understanding and requires practice and reminders to foster new skill development.	5.4
Teach-Back Training Flyer Template	To promote and create awareness of teach-back training available for staff.	Using the train-the-trainer approach teaches staff to use teach-back and makes teach-back more familiar to everyone.	5.5
Teach-Back Methodology for Patient Education: Employee Competency Validation Checklist	This template may be used as a validation tool when implementing teach-back within an organization.	Ensuring each staff member preforms teach-back appropriately is essential.	5.6

Practice Experiences:
"I decided to do teach-back on five patients. With one mother and her child, I concluded the visit by saying, 'So tell me what you are going to do when you get home?' She could not tell me what instructions I had just given her. I explained the instructions again and then she was able to teach them back to me. I had no idea she did not understand—I was so wrapped up in delivering the message that I did not realize it wasn't being received."

www.hsag.com/hqic/tools-resources/readmissions/care-coordination-toolkit/#_TeachBack

Patient Education: Zone Tool

My Plan to Identify Infection and/or Sepsis

Name ______________________________ Date ____________________ Do not smoke; avoid secondhand smoke.

Green Zone: No Signs of Infection (all below)

- ✓ My heartbeat and breathing feel normal for me.
- ✓ I don't have chills or feel cold.
- ✓ My energy level is normal.
- ✓ I can think clearly.
- ✓ Any wound or IV site I have is healing well.

Green Means I Should:

- ✓ Watch every day for signs of infection.
- ✓ Continue to take my medicine as ordered, especially if I'm recovering from an infection or illness.
- ✓ Keep my doctor and other appointments.
- ✓ Follow instructions if I'm caring for a wound or IV site.
- ✓ Wash my hands and avoid anyone who is ill.

Yellow Zone: Caution (any below)

- ✓ My heartbeat feels faster than usual.
- ✓ My breathing is fast, or I'm coughing.
- ✓ I have a fever between 100.0°F and 101.4°F.
- ✓ I feel cold and am shivering—I can't get warm.
- ✓ My thinking is slow—my head is "fuzzy."
- ✓ I don't feel well—I'm too tired to do things.
- ✓ I haven't urinated in 5 hours or it's painful or burning when I do.
- ✓ Any wound or IV site I have looks different.

Yellow Means I Should:

- ✓ Contact my doctor, especially if I've recently been ill or had surgery.
- ✓ Ask if I might have an infection or sepsis.

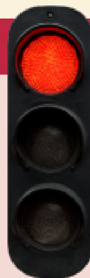
Physician Contact:

Doctor: ______________________________

Phone: ______________________________

Red Zone: Medical Alert! (any below)

- ✓ I feel sick, very tired, weak, and achy.
- ✓ My heartbeat or breathing is very fast.
- ✓ My temperature is 101.5°F or greater.
- ✓ My temperature is below 96.8°F.
- ✓ My fingernails are pale or blue.
- ✓ People say I'm not making sense.
- ✓ My wound or IV site is painful, red, smells, or has pus.



Red Means I Must:

- ✓ ***Act fast … Sepsis is serious!***
- ✓ **Call 9-1-1** and say, "I need to be evaluated immediately. I'm concerned about sepsis."

www.hsag.com/globalassets/hqic/zonetool_sepsis_hqic.pdf
www.hsag.com/globalassets/hqic/zonetool_sepsis_hqic_sp.pdf

HSAG HQIC

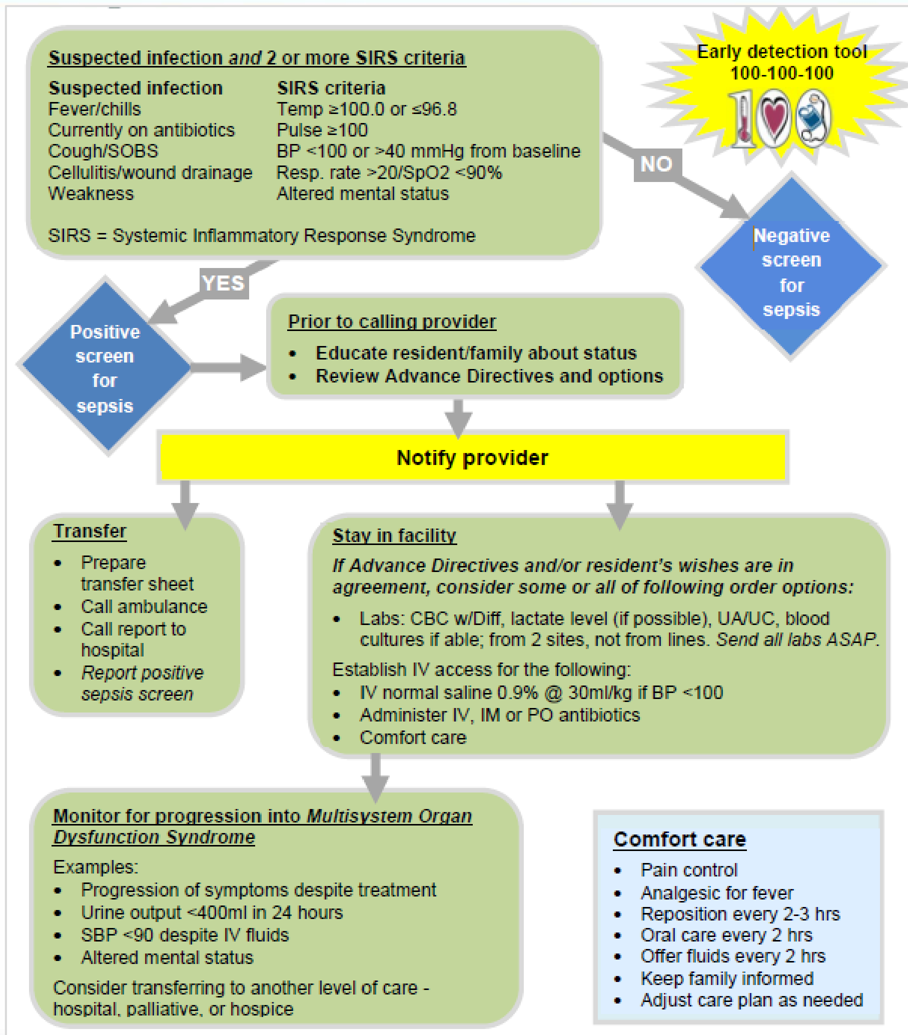
Sepsis Patient Education

- Sepsis definition and diagnosis
- Source of infection
- Risk factors for sepsis
- What happened during hospitalization
- Where they are going next
- What to expect after discharge
- Signs of PSS
- Resources

 www.sepsis.org/sepsis-basics/what-is-sepsis

HSAG HQIC

Seeing Sepsis: SNF Sepsis Algorithm for Adults



seeing sepsis

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

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

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

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

U.S. Dept. of Health & Human Services Partnership for Patients (HSS), Betsy Lehman Center for Patient Safety. *Seeing Sepsis algorithm for SNFs.* betsylehmancenterma.gov/assets/uploads/SepsisLTSS-SeeingSepsisAlgorithm.pdf
HSS. Minnesota Hospital Association. Seeing Sepsis tools.
www.mnhospitals.org/Portals/0/Documents/ptsafety/SeeingSepsisLTC/1.%20Seeing%20Sepsis%20-%20LTC%20Poster.pdf

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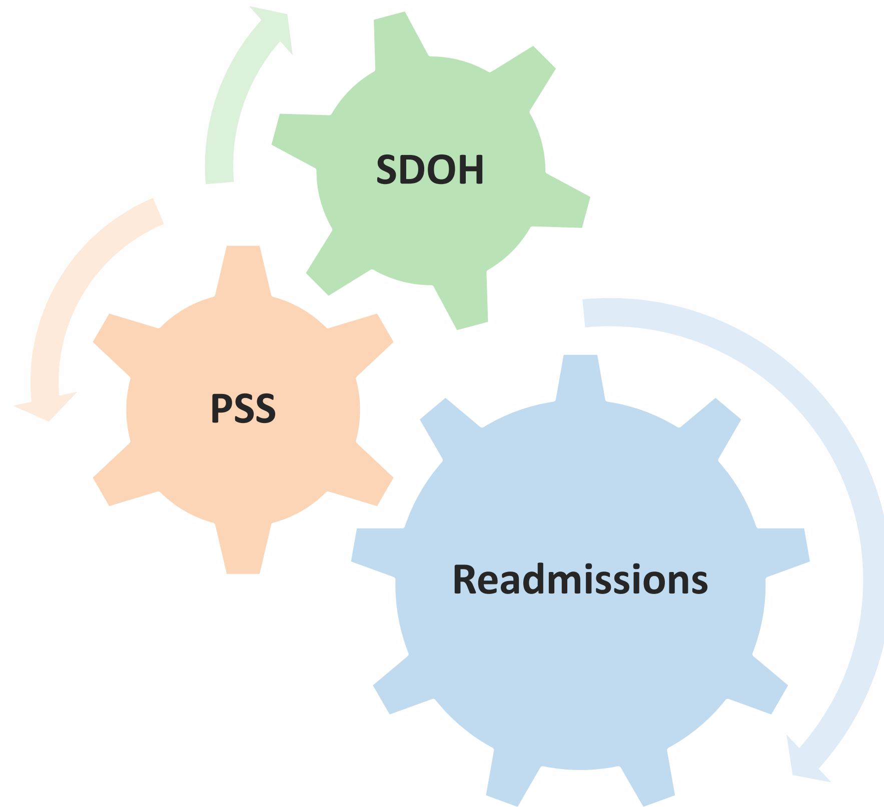
Putting It All Together



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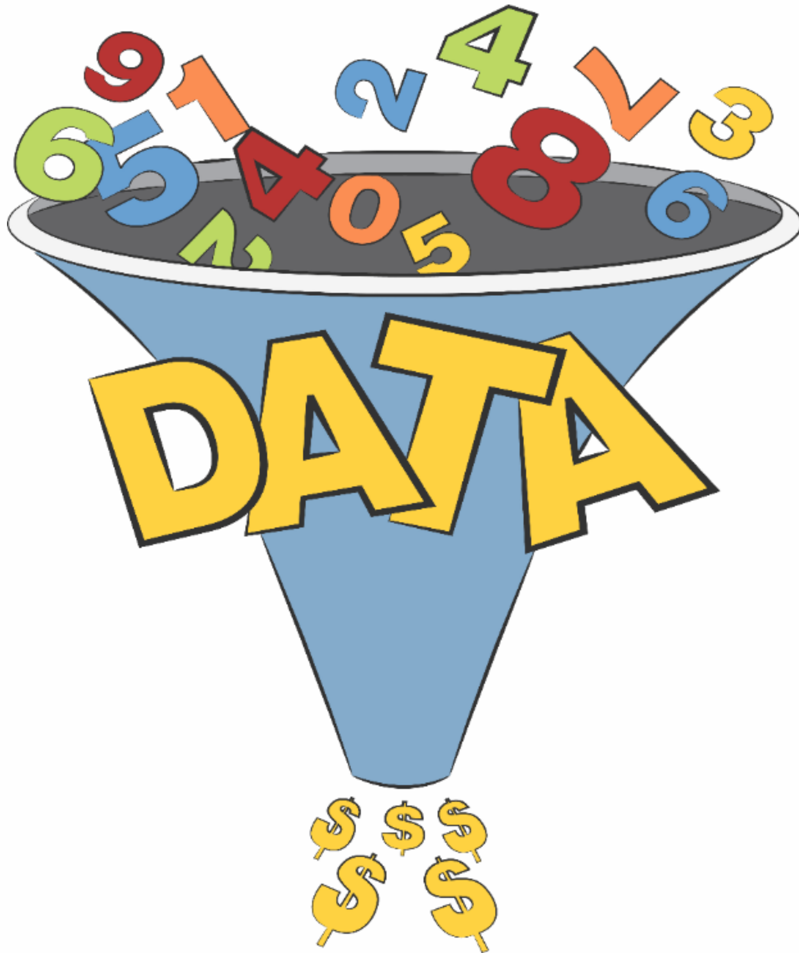
Monitor and Course Correct



- Interview readmitted patients.
- Review records of readmitted patients.
- Include SDOH as data elements.
- Track and trend data.
- Pilot new strategies based upon data.

HSAG HQIC 7-Day Readmission Chart Audit Tool.
www.hsag.com/contentassets/a54753d6b94d4d289154db7d0222fde1/3.3_7-day-readmission-chart-audit-tool-hqic.pdf
HSAG HQIC Readmission Interview Tool.
www.hsag.com/contentassets/a54753d6b94d4d289154db7d0222fde1/3.4_readmission-patient-interview-tool-hqic.pdf

Some New Sepsis Prevention Ideas to Ponder

Schedule a sepsis day of the week.

- A day to increase awareness of sepsis.

Promote a whole food, plant-based diet.

- Consider low-fat options for providers, staff, visitors, and patients.

AHA. Healthy Food in Health Care Hospital Toolkit. pcrm.widen.net/s/wj25h99nwn

AHA. Hospitalization as a Teachable Moment: Plant-Based Options on Patient Trays. Webinar recording. www.aha.org/education-events/hospitalization-teachable-moment-plant-based-options-patient-trays-apr-26

Tools and Resources: Sepsis Mortality Reduction

- Sepsis Roadmap for Larger Hospitals. www.hsag.com/globalassets/hqic/hqic_sepsisacutecare_roadmap.pdf
- Sepsis Roadmap for Critical Access Hospitals. www.hsag.com/globalassets/hqic/hqic_sepsiscah_roadmap.pdf
- Sepsis Time is Tissue Tool. www.hsag.com/globalassets/hqic/hqic_sepsistimetissuetool.pdf
- Sepsis Mortality Toolkit. www.hsag.com/globalassets/hqic/hsaghqic_sepsismortalitytoolkit.pdf

Tools and Resources: Sepsis Readmission Prevention

- Teach-Back. www.hsag.com/hqic/tools-resources/readmissions/care-coordination-toolkit
- Zone Tools. www.hsag.com/globalassets/hqic/zonetool_sepsis_hqic.pdf
- Discharge Risk Assessment. www.hsag.com/globalassets/hqic/hqic_dischargeriskassessment.pdf
- Social Work Assessment. www.hsag.com/globalassets/hqic/hqic_socialworkassessment.pdf
- Let Home Health In Video. www.youtube.com/embed/mPUOiH2DiJo
- 7-Day Readmission Chart Audit Tool. www.hsag.com/contentassets/a54753d6b94d4d289154db7d0222fde1/3.3_7-day-readmission-chart-audit-tool-hqic.pdf
- Readmission Interview Tool. www.hsag.com/contentassets/a54753d6b94d4d289154db7d0222fde1/3.4_readmission-patient-interview-tool-hqic.pdf
- Post Sepsis Syndrome from CDC. www.cdc.gov/sepsis/pdfs/life-after-sepsis-fact-sheet.pdf
- Post Sepsis Syndrome Video from Sepsis Alliance. www.sepsis.org/sepsis-basics/post-sepsis-syndrome
- Readmission Prevention Roadmap to Success. www.hsag.com/globalassets/hqic/hqic_readmission_roadmap_508.pdf

Discharge Risk Assessment

Patient Discharge Disposition:

- ☐ Lives at home with limited or no community support
- ☐ Requires assistance with medication management
- ☐ Polypharmacy (more than 7 medications)
- ☐ History of mental illness
- ☐ Issues with health literacy
- ☐ Requires assistance with ADLs/IADLs
- ☐ Cognitive impairment
- ☐ End-stage conditions *
- ☐ Diagnosis: CHF/COPD/ diabetes/HIV/AIDS
- ☐ Incontinent
- ☐ Acute/chronic wound or pressure ulcer
- ☐ History of falls
- ☐ Decreased adherence to treatment plan
- ☐ Repeat hospitalization/ED visits
- ☐ Requires assistance with managing oxygen and/or nebulizer

TOTAL # CHECKED: ___________

SCORE ≥ 5 This patient is at HIGH RISK for rehospitalization. Refer to home care services immediately.
SCORE 2–4 This patient is at MODERATE RISK for rehospitalization. Refer to home care services prior to discharge.
SCORE < 2 This patient is at LOW RISK for rehospitalization. Discharge.

Life-Limiting Conditions:

* If the patient has an end-stage/life-limiting condition and any of the following, consider hospice evaluation or referral.

- ☐ Recent impaired nutritional status, as evidenced by unintentional weight loss of ≥ 10 percent over the last 6 months or serum albumin < 2.5
- ☐ Recent decline of functional status (Karnofsky score of <50)
- ☐ Unrelieved physical symptoms that are difficult to manage
- ☐ Poor response to optimal treatment
- ☐ Frequent ED visits and/or hospitalization
- ☐ Patient is considered terminally ill when the medical prognosis is such that the individual life expectancy is 6 months or less if the illness runs its normal course

*Hospice patients need not be homebound

Other Care Needs:

Skilled Nursing

- ☐ Observation and assessment
- ☐ Teaching and training
- ☐ Performance of skilled treatment of procedure
- ☐ Management and evaluation of a client care plan following an acute episode

And/or Other Care

- ☐ Physical, occupational and/or speech therapy
- ☐ Medical social work
- ☐ Home health aide service for personal care and/or therapeutic exercises
- ☐ Tele-healthcare management

To Qualify for Medicare Home Health Services:

- The patient is under the care of physician (community physician willing to sign home care orders).
- The patient is homebound.
- The patient requires at least one skilled professional service (RN, PT, speech on an intermittent basis). OT and home health may be added under a skilled service.
- Services are provided in the patient's home.
- Services must be reasonable and necessary.

Definition of Homebound: The condition of the patient causes a considerable and taxing effort for the patient to leave home.

Homebound Qualifiers:

- Absences from the home are infrequent or of short duration.
  Examples of infrequent or short duration absences:
  - Attendance at religious services
  - Attendance at a significant family event
  - Trip to barber or hairdresser
  - Walk outdoors
- To receive healthcare treatment.
- To receive medical day care services.

If patient referred to home healthcare prior to discharge:

Agency: ______________________________

City/State: ____________________________

www.hsag.com/globalassets/hqic/hqic_dischargeriskassessment.pdf

Tools and Resources: Providers and Staff

Sepsis Education & Expertise

- Buy In. www.hsag.com/hqic/quality-series
- Simple Sepsis Pathophysiology. www.hsag.com/globalassets/hqic/hqicsimplesepsispathophysiology.pdf
- Sepsis Alliance Institute. learn.sepsis.org
- Physician education. qioprogram.org/tools-resources/compass-hqic-network-podcast-sepsis-physician-education
- Nursing education. qioprogram.org/tools-resources/compass-hqic-network-podcast-sepsis-nurse-education

Tools and Resources: Sepsis Prevention

Including preventing conditions that increase risk of sepsis

- AHA Hospitalization as a Teachable Moment: Plant-Based Options on Patient Trays.
  - Webinar recording. www.aha.org/education-events/hospitalization-teachable-moment-plant-based-options-patient-trays-apr-26
  - Slides. www.aha.org/system/files/media/file/2023/05/AHA_Team_Training_Sponsored_Webinar_Slides_PCRM_Apr_2023.pdf
- Healthy Food in Health Care Hospital Toolkit. pcrm.widen.net/s/wj25h99nwn
- Adventist Health Recipe Booklet. pcrm.widen.net/s/bppdfldktr
- Eliminating Processed Meat Bifold Brochure. pcrm.widen.net/s/vn5vqhl5nv
- Cancer Prevention Starts With Breakfast (table tent). pcrm.widen.net/s/qd7xg9wjrv
- A Plant-Based Diet Is Powerful Medicine (table tent). pcrm.widen.net/s/9dssp5qxmv
- HSAG HQIC Post-op Sepsis Checklist. www.hsag.com/globalassets/hqic/hsag_hqic_postopsepsischecklist.pdf
- HSAG HQIC Clean Hands Pledge (English). www.hsag.com/globalassets/hqic/hqic_cleanhandspledge.pdf
- HSAG HQIC Clean Hands Pledge (Spanish). www.hsag.com/globalassets/hqic/hqic_cleanhandspledge_sp.pdf
- Sepsis Alliance. Sepsis Prevention. 2022. www.sepsis.org/sepsis-basics/prevention
- Veterans Administration. (2017). Brush Your Teeth to Prevent Pneumonia Brochure. www.va.gov/innovationecosystem/assets/documents/PneumoniaTeeth_Brochure_Feb2020.pdf

Key Concepts

- Use teach-back.
- Educate patients and family regarding sepsis and PSS.
- Discharge to the appropriate level of care.
- Collaborate with community.
- Interview readmitted patients.
- Review records of readmitted patients.
- Track and trend SDOH from interviews and record review.
- If you have no trends, then you need more data.

QUESTIONS?

Thank you

This material was prepared by Health Services Advisory Group (HSAG), a Hospital Quality Improvement Contractor (HQIC) 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 No. XS-HQIC-IP-06282023-01

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