HSAG’s Efforts with Sepsis within Long-Term Care Facilities (LTCFs)

Objectives

• Identify quality improvement programs that may help with sepsis efforts.
• Utilize tools and resources that may support your sepsis efforts.
• Recognize the importance of early recognition and intervention regarding sepsis in post-acute settings.

What is a QIN-QIO*?

• Funded by the Centers for Medicare & Medicaid Services (CMS)
  - QIN-QIO in each state
  - Dedicated to improving health quality at the community level
  - Ensures people with Medicare get the care they deserve, and improves care for everyone

*QIN-QIO=Quality Innovation Network-Quality Improvement Organization
Sepsis and Coordination of Care

New National QIN-QIO Structure

HSAG’s QIN-QIO Responsibility

Nearly 25 percent of the nation’s Medicare beneficiaries

HSAG is the Medicare QIN-QIO for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.

Medical Case Review Structural Changes

CMS separated medical case review from quality improvement work creating two separate structures:

Medical Case Review
Beneficiary Family Centered Care-QIOs (BFCC-QIOs)

Quality Improvement
Quality Innovation Network-QIOs (QIN-QIOs)
Better Healthcare for Communities: Improve Coordination of Care

- Reduce hospital readmission rates for Medicare Fee-For-Service patients by 20 percent by 2019.
- Improve overall community health and support self-care of individuals in their homes.
- Reduce adverse drug events (ADEs) that contribute to patient harm as a result of the care transitions process.
- Convene community providers to collaborate on strategies for improvement in care coordination.
What is a Hospital Readmission?

- CMS defines a readmission in this context as “an admission to a subsection(d) hospital within 30 days of a discharge from the same or another subsection(d) hospital.”
- Subsection(d) hospitals, per the Social Security Act, include short-term inpatient acute care hospitals excluding critical access, psychiatric, rehabilitation, long-term care (LTC), children’s, and cancer hospitals.

Why Focus on Rehospitalizations?

- Resident/patient quality of life/quality of care
- Survey and certification
- Future penalties
- Value-based payment (VBP)

All-Cause Readmission Rates for Ohio Skilled Nursing Facility (SNF) by Region (Q1 2017–Q4 2017)

Ohio Average 16.6%

Source: Q1 2017 through Q4 2017 Medicare Fee-for-Service (FFS) all-cause claims data
All-Cause Readmission Rates for Ohio Home Health Agencies (HHA) by Region (Q1 2017–Q4 2017)

Ohio Average 11.9%

Source: Q1 2016 through Q3 2017 Medicare FFS all-cause claims data

Communities of Focus

Source: Q4 2016 through Q3 2017 Medicare FFS all-cause claims data

How Does Sepsis Fit Into Care Coordination?
Impact of Sepsis

- Sepsis is the most expensive diagnosis, leading to readmissions costing more than $3.1 billion per year (2013 data).
- Sepsis is responsible for the most readmissions to a hospital within 30 days after a hospital visit (more than 191,000 readmissions each year).

First Effort: Early Sepsis Recognition in LTC and Home Health Settings Event

- First statewide swing at sepsis
- Supported by state and federal partners
- GAP analysis completed by attendees

Early Sepsis Recognition in LTC and Home Health Settings Event: GAP Analysis

- Recognize strengths and opportunities to improve
- Variety of categories including education, leadership, resources, and more
- Some standout results:
  - 70 percent of the attendees felt they had the resources to effectively deal with sepsis
  - Only 19 percent of the attendees performed case reviews to look for gaps in performance in regards to sepsis
Current Approaches to Sepsis: QI Programs

- Nursing Home Reducing Readmissions Preparation Program (RRPP)
- National Nursing Home Quality Improvement Campaign (NNHQIC)

Feedback From the Frontlines

Sepsis in the elderly is often hard to identify
- Symptoms commonly used to identify infection and organ dysfunction are masked in older adults with multiple comorbidities
  - SNFs and home health agencies (HHA) feel like tools and resources for the post acute areas were not readily available
  - Acute care facilities stated that the post acute partners were sending the patient when they were crashing
  - How do we get two care partners to agree on an approach?

The Ask

- SNF and HHAs
  - Provide tools that address our unique population
  - Understand our capabilities
  - Help us communicate in the same language with providers and partners
- Acute Care Facilities
  - Identify a potential Sepsis case as soon as possible
  - Intervene if the resident condition is appropriate
  - Transfer for evaluation prior to deterioration
Sepsis and Coordination of Care

Educating Staff Members

Assessing for Subtle Changes

http://www.pathway-interact.com/

Communicating Concerns

Post-Acute Situation Background Assessment Recommendations (SABR) for Sepsis

Health Services Advisory Group
Communicating Concerns (cont.)

Part Acute Situation Background Assessment Recommendation (SBAR) for Sepsis

Assessment:
1. Hypothermia
2. Hypertension
3. Hypoxia
4. Hyperkalemia

Recommendation:
1. Use SBAR for early intervention

Stop and watch
- Proven effectiveness as an early intervention tool
- Consistent implementation is crucial
  - Challenges: turnover, training, off shifts

Situation, Background, Assessment, Recommendation (SBAR)
- Streamlined processes
- Education tool for clinical staff members and providers
- Standardized communication
  - Challenges: the same

Ohio Hospital Association Data
- 15.5% reduction since 2014 Baseline
Additional Resources

- HSAG Website
- Minnesota Hospital Association/Minnesota Department of Health
- INTERACT®

Contact HSAG or go to http://www.pathway-interact.com/

Questions

Thank you!