Reducing Sepsis Mortality at Wake Health

An Inside Look at the Development of a Comprehensive Turnaround
Today’s Presenters

Megan Zweig
Physician Executive Council Consultant
202-266-5416
ZweigM@advisory.com

Dr. Cathy Jones, MD, MS
Wake Forest Baptist Health
Associate Chief Medical Officer

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
The Physician Executive Council

The New Physician Leadership Team

Traditional Responsibilities

- Enterprise quality strategy, efforts
- Population health management
- Credentialing
- Leveraging data, IT to inflect outcomes
- Medical staff liaison
- Enterprise physician performance management
- Quality Improvement
- Integrating cost implications into clinical decision-making
- System clinical standardization

Emerging Responsibilities

- CME\(^1\)
- Utilization review
- Reviewing payer contracts
- Chronic disease management
- Peer Review
- Reviewing payer contracts
- System clinical standardization

The Physician Executive Council Membership at a Glance

- Research membership focused on supporting the CMO and team with best demonstrated practices, insights, tools, expert consultations, and networking opportunities
- Research aimed at elevating performance management, transforming clinical care delivery, and minimizing care variation
- Webconferences, tools, and publications tailored to clinical leadership team (VPMA, CQO, CMIO) and emerging physician leaders

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1) Continuing medical education.

Source: Physician Executive Council interviews and analysis.
Did You Miss our Previous Sepsis Webconference?

Access Part One of the Sepsis Webconference Series Online

View the “Playbook for Elevating Septicemia Care” here:

http://www.advisory.com/Technology/Crimson-Continuum-of-Care/Members/Events/Webconferences/2013/Playbook-for-Elevating-Septicemia-Care

What You’ll Learn

- How to customize sepsis detection strategies for the ED, ICU, and inpatient floor
- Tactics to accelerate sepsis care delivery and hardwire bundle adherence
- Access sample sepsis protocols, screening tools, and skill gap assessments
- Size your organization’s sepsis opportunity in terms of mortality, LOS, and cost per case

Source: Crimson Continuum of Care and Physician Executive Council interviews and analysis.

1) For Crimson Continuum of Care members.
Sepsis Remains A Serious, and Growing, Challenge

Rising Volumes

- **750K** New Cases Yearly
- **65%** Patients Elderly

Poor Outcomes

- **#1** Non-coronary Deaths
- **30-50%** 28day Mortality

Extreme Costs

- **$22,100** Cost/Case
- **6x** Higher ICU Costs

Sepsis Mortality Rates Are Not Alike Across All Hospitals

- **SepticShock**
  - 25th Percentile: 29.8%
  - Average: 34.7%
  - 75th Percentile: 40%

- **SevereSepsis**
  - 25th Percentile: 13.8%
  - Average: 18.9%
  - 75th Percentile: 23.4%

Progress Lags Despite Decade-long Campaign

Surviving Sepsis Campaign Yet to Curb Rising Sepsis Mortality Rates

2002

Goal: To reduce mortality from sepsis by 25% by 2009 via a seven-point agenda including:

- Building awareness of sepsis
- Improving diagnosis
- Increasing the use of appropriate treatment
- Educating healthcare professionals
- Improving post-ICU care
- Developing guidelines of care
- Implementing a performance improvement program

Sepsis Guidelines Effective, but Underutilized

17% Increase in sepsis inpatient hospital death rates in the past decade

19% Physicians who follow pediatric sepsis guidelines

31% Physicians who adhere to 6-hour sepsis resuscitation bundle

Many Hurdles Along Path to Delivering Sepsis Care

**TRIAGE**
- ✓ Suspect Sepsis
- ✓ Screen for Sepsis
- ✓ Identify Positive Screens
- ✓ Inform Physician
- ✓ Kick-off 6hr Bundle
- ✓ Order sepsis panel*

**EARLY RESUSCITATION**
- ✓ Draw Cultures and Lactate
- ✓ Give Antibiotics
- ✓ Collect Test Results
- ✓ Alert ICU or RRT
- ✓ CVC Insertion*
- ✓ EGDT Monitoring*

**ONGOING MANAGEMENT**
- ✓ ICU/Floor Transfer*
- ✓ Hand-off Remaining Bundle Steps*
- ✓ Repeat Lactate
- ✓ Collect Culture Results
- ✓ Adjust Antibiotics*

47% Fail to order lactate with Blood Culture¹

50% Fail to administer antibiotics within 6hrs

72% Fail to document specific microbe¹

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¹Tasks requiring skillset beyond typical practice or license OR tasks requiring transfer of location or task owner at hospital
¹ From Crimson Cohort Analysis.

Source: Crimson Cohort Analysis; Critical Care Medicine, Kumar, Anand MD et al; Volume 34(6), June 2006, pp 1589-1596.
Introducing Wake Forest Baptist Health

Case in Brief: Wake Forest Baptist Health

- 3-hospital system headquartered in Winston Salem, North Carolina
- After recognizing excess sepsis deaths within the system, leadership convened multidisciplinary performance improvement group in 2012 to design and implement a comprehensive sepsis initiative in the ED, ICU, and inpatient floors
- Dr. Jones, Associate Chief Medical Officer, spearheaded the initiative
- Initiative achieved impressive results, including: reduced time to antibiotic administration, increased sepsis bundle adherence, reduced length of stay, and reduced mortality

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Stepwise Approach Allows Initiative Refinement Along the Way

Timeline of Sepsis Initiative at Wake Forest Baptist Health

July 2011
Leaders identify excess sepsis deaths using UHC¹ risk adjustment model¹

April 2012
Inpatient floor units adopt new protocols

November 2012
Multidisciplinary group meets to discuss how to translate inpatient sepsis protocol to ICU

February 2012
Multidisciplinary group develops new sepsis protocols for inpatient floors, including screening tools and sepsis bundle prompts

July-August 2013
CCU and MICU adopt new protocols

July 2013
All units currently sustaining improvements in bundle compliance, LOS, and mortality

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.

¹ University HealthSystem Consortium.
Wake Health’s Barriers to Optimal Sepsis Care Reflect Industry-wide Challenges

Multidisciplinary Staff Meeting to Uncover Barriers to Optimal Sepsis Care at Wake Health

Meeting Attendees
- Performance improvement experts
- Faculty and house staff from medical, surgery, and neurology departments
- ICU physicians
- Respiratory therapy leaders
- Frontline nurses
- Pharmacists
- Rapid response team

Identified Barriers
- Lack of education on sepsis and sepsis initiative among frontline staff
- Responsibilities for identifying and treating sepsis in rapid timeframe not well-defined
- Guidelines not consistently followed in time-sensitive window
- Clinicians took often take ad-hoc approach to screening and miss diagnoses

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
## Reducing Sepsis Mortality at Wake Health

### Eight Tactics for Promoting Consistent, High-Quality Sepsis Care

<table>
<thead>
<tr>
<th>I: Formalize Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inpatient early warning sepsis screen</td>
</tr>
<tr>
<td>2. Acuity-sensitive ICU sepsis trigger</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II: Accelerate Treatment</th>
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</thead>
<tbody>
<tr>
<td>3. Simplified sepsis bundle</td>
</tr>
<tr>
<td>4. Top-of-license sepsis roles</td>
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<tr>
<td>5. Rapid response sepsis kit</td>
</tr>
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<td>6. Comfort care decision prompt</td>
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<thead>
<tr>
<th>III: Hardwire Accountability</th>
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<tr>
<td>7. Real-time protocol checklist</td>
</tr>
<tr>
<td>8. Phased bundle adherence accountability</td>
</tr>
</tbody>
</table>

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Road Map

1. Formalize Identification
2. Accelerate Treatment
3. Hardwire Accountability
Definition of “Code Sepsis” at Wake Health

A patient emergency requiring immediate action for the treatment of potential sepsis and septic shock. Includes a standardized process for:

• Early identification, communication, and intervention for patients with sepsis

• Implementing the sepsis bundle (including antibiotics) within one hour

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
### Barriers to Early Identification

- Subtle symptoms often fly under the radar
- Floor nurses not exposed to many sepsis cases
- Nurses reluctant to sound alarm because of false positive
- All clinicians extremely busy

### Sepsis Identification Process Across Inpatient Floor, ED, and ICU

<table>
<thead>
<tr>
<th>Site of Care</th>
<th>Screen Used</th>
<th>Provider Responsible for Screening</th>
<th>Screening Frequency</th>
</tr>
</thead>
</table>
| Inpatient Floor | Early Warning Score (includes SIRS criteria and alertness scale) | Nursing assistant checks vital signs and RN evaluates patient alertness | • Every four hours for first 24 hours post-admission  
• If patient is stable after 24 hours (i.e., EWS\(^1\)<5), every eight hours  
• If EWS is between 5-7, every four hours |
| ICU | SIRS and “snooze criteria”\(^2\) | Bedside nurse | • Upon ICU admission  
• Every 12 hours or as needed |
| ED | EWS\(^1\) | RN | • During ED triage |

1) Early Warning Score  
2) For more information, please see slide 19 in this presentation.

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Early Warning Score Criteria

*Used on Inpatient Floors and ED*

<table>
<thead>
<tr>
<th>Points</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>Systolic BP</td>
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<tr>
<td>≤ 90</td>
<td>≤ 91 – 100</td>
<td>101 – 110</td>
<td>111 – 219</td>
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<td>≥ 220</td>
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<tr>
<td>≥ 95</td>
<td>95.1 – 96.8</td>
<td>96.9 – 100.4</td>
<td>100.5 – 102.2</td>
<td>≥ 102.3</td>
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<tr>
<td>Pulse</td>
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<td>≤ 40</td>
<td>41 - 50</td>
<td>51 – 90</td>
<td>91 – 110</td>
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<td>Resp Rate</td>
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<tr>
<td>≤ 8</td>
<td>9 - 11</td>
<td>12 – 20</td>
<td>21 – 24</td>
<td>≥ 25</td>
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<tr>
<td>Oxygen Saturation</td>
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<td>≤ 91</td>
<td>92-93</td>
<td>94 – 95</td>
<td>≥ 96</td>
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<tr>
<td>Oxygen Saturation</td>
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<tr>
<td>Inspired O₂</td>
<td>Room Air</td>
<td>Supplemen-tal O₂</td>
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<tr>
<td>Alertness Scale</td>
<td>Alert</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Voice, Pain or Unresponsive</td>
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</tr>
</tbody>
</table>


EWS ≥ 8
*Mortality ≥ 10%
Activate Rapid Response

EWS 5 – 7
Increased mortality
VS Q 4 Hours

EWS 0 – 4
Normal risk
VS Q 8 Hours
*Internal Data

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Hitting the “Snooze” to Reduce False Alarms

“The sepsis trigger needs to be like an alarm clock when you hit the snooze alarm. ICU patients will meet SIRS criteria for a period of time and it shouldn’t always trigger an alert.”

ICU Physician, Wake Forest Baptist Health

Patient Timeline in ICU

“Snooze Phase”
Patients expected to meet SIRS criteria, but not have sepsis; nurses do not trigger sepsis alert

“Post-Snooze Phase”
Nurses conduct sepsis screen every 12 hours or as needed; if positive for SIRS, nurse draws lactate; if abnormal lactate and/or potential infection, calls Code Sepsis

Duration of “Snooze Phase,” by Treatment

<table>
<thead>
<tr>
<th>If a patient is…</th>
<th>Snooze them for…</th>
</tr>
</thead>
<tbody>
<tr>
<td>On ABX For Sepsis</td>
<td>96 hours from new ABX start/change in ABX</td>
</tr>
<tr>
<td>Patient has CT Surgery</td>
<td>48 hours from return to unit</td>
</tr>
<tr>
<td>Trauma Patient</td>
<td>48 hours from arrival to facility</td>
</tr>
</tbody>
</table>

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
## Complete “Snooze” Criteria

From Wake Forest Baptist Health

**Length of Time Per “Snooze” Based on Diagnosis**

“Snooze” Time Must Elapse Before Triggering a Sepsis Alert for Patients Who Meet SIRS Criteria

<table>
<thead>
<tr>
<th>If a patient is...</th>
<th>Snooze them for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>On ABX for Sepsis</td>
<td>96 hrs from new ABX start/change in ABX</td>
</tr>
<tr>
<td>Post-Arrest Hypothermia Protocol Patients</td>
<td>72 hours from arrival to facility</td>
</tr>
<tr>
<td>DNR Soto Comfort Care Order or No Escalation of Care</td>
<td>Permanent, unless order changed</td>
</tr>
<tr>
<td>Trauma Patient</td>
<td>48 hours from arrival to facility</td>
</tr>
<tr>
<td>Patient has CT Surgery</td>
<td>48 hours from return to unit</td>
</tr>
<tr>
<td>AMI Patients (Including STEMIs)</td>
<td>48 hours from return to unit</td>
</tr>
<tr>
<td>TAVR Value</td>
<td>24 hours from return to unit</td>
</tr>
<tr>
<td>Intracranial Bleed (IB)</td>
<td>24 hours from arrival to ED</td>
</tr>
<tr>
<td>Surgery (incl. Mobile OR)*</td>
<td>24 hours from return to unit * If IR, consult 1st call provider</td>
</tr>
</tbody>
</table>

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Road Map

1. Formalize Identification

2. Accelerate Treatment

3. Hardwire Accountability
Rapid Treatment Crucial to Reduce Mortality

Impact of Compliance with 6-hour Sepsis Bundle on Hospital Mortality

- 55% Not compliant with 6-hour bundle
- 29% Compliant with 6-hour bundle

89% increase in risk of death if patient does not receive six-hour bundle

1 hour Delay in Antimicrobials  
7.6% Increase in Mortality


1) For patients with severe sepsis.
Drawing the Link From Staff Activities to Mortality

PPT Slide Used in Presentation to Wake Health Floor Staff

Time to 1<sup>st</sup> antibiotic dose is the most important predictor of survival in sepsis!

During presentation, leaders also highlighted organizational performance compared to study performance to demonstrate their own improvement opportunity.

Simplified Sepsis Bundle

Simplifying Guidelines to a Four-Component Bundle

Complete Sepsis Protocol:

1. Measure serum lactate
2. Obtain blood cultures prior to antibiotic administration
3. Administer broad-spectrum antibiotics within one hour
4. Fluid resuscitation if MAP$^1 < 65$ or elevated lactate

Simplified, Time-Sensitive Sepsis Resuscitation Bundle at Wake Forest Baptist Health

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.

1) Mean arterial pressure.
Defined Roles Expedite Sepsis Care on the Floor

Initial Sepsis Care Actions and Parties Responsible at Wake Health

For Inpatient Floor Code Sepsis

1. Nursing Assistant
   Completes initial Early Warning Score screening

2. Bedside Nurse
   Evaluates mental status, calculates EWS$^1$, and calls first call provider and rapid response nurse if needed

3. Rapid Response RN
   Pages “Code Sepsis” team, initiates sepsis bundle starting with lactate tests and blood cultures

4. First Call Provider$^2$
   Confirms potential sepsis

5. Rapid Response Team
   ICU RN, stat lab, pharmacist, and respiratory therapist receive Code Sepsis page

6. Unit Secretary
   Receives call from pharmacist when broad-spectrum antibiotic is on its way, ensures delivery to bedside

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$^1$ Early Warning Score.  
$^2$ First call provider can be NP, PA, Intern, or Hospitalist. They are called at same time as Rapid Response RN, though typically the RN gets to the bedside prior to the first call provider.

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Empowering Staff to Practice at Top-of-License

Wake Health Heavily Relies on Nurses, Pharmacists to Initiate Bundle

**Rapid Response Nurses**

- All Rapid Response Nurses have critical care experience and are highly regarded by the medical staff.
- Nurses take lactate tests to stat lab and draw blood cultures for Code Sepsis patients.
- Physicians agreed to pass on these responsibilities to RNs after data showed physicians were not consistently doing lactate tests.

**Pharmacists**

- Pharmacist monitors timing between Code Sepsis page and receiving antibiotic order from physician; follows up with first-call provider if order is not received in a timely manner.
- Once a physician verbally confirms sepsis and site of infection to pharmacist over the phone, pharmacist places order for appropriate broad-spectrum antibiotics.
- Pharmacist delivers antibiotics directly to Code Sepsis patient’s bedside.

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Minimizing Time Wasted on Gathering Supplies

Sepsis Kit Ensures All Necessary Supplies Quickly Available to RRT

Rapid Response Sepsis Kit Supply List

- 2 sets BC bottles
- 4 chlorapreps
- 3 transfer devices
- 2 gold top tubes
- 1 purple top tube
- 1 blue top tube
- 1 gray top tube
- (4) 10cc syringes
- Blood gas kit
- Blood gas manual slip
- Alcohol preps
- Gauze
- IV start kit
- Lab bags
- (2) 10cc ns flushes
- Tourniquet

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
When Curative Treatment is Not the Goal

Physician Feedback Prompts
Mandated Comfort Care Decision

- Physician feedback reveals providers occasionally choosing not to deliver sepsis bundle because it does not align with patient care goal of comfort care
- Wake Health trains first call physicians to consider patient care goals before initiating sepsis bundle
- Physicians may opt out of Rapid Response Team trigger if patient and family decide to pursue palliative care or hospice

Sample Treatment Decision Tree
Before Calling RRT

1. Is curative treatment in the patient’s care plan?
   - Yes
     - Call RRT to initiate bundle
   - No
     - Connect patient and family with palliative and end-of-life care planning
     - Disable automatic RRT trigger for patient

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.

1) Rapid Response Team.
Considering Patient Care Goals Improves Mortality Index at Wake Health

Sepsis Diagnosis Triggers Consideration of “Hospice in Place” Option

Sepsis Mortality Index at Wake Health Before and After Sepsis Initiative and “Hospice in Place” Rollout

- Pre-Code Sepsis: 1.5
- Post- Floor "Code Sepsis": 1.3, 1.2
- Post- Floor, ED and ICU "Code Sepsis": 0.9, 0.7

- Sepsis Mortality Index Including Terminally Ill
- Sepsis Mortality Index Excluding "Hospice in Place" Patients

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Road Map

1. Formalize Identification
2. Accelerate Treatment
3. **Hardwire Accountability**
Real-Time Protocol Checklist

Driving Bundle Compliance, Real-Time

Rapid Responses Sepsis Screening Tool at Wake Health

Checklist completed by the rapid response nurse

Completed checklist faxed to Performance Improvement Department to track compliance

Tool embedded in EMR, but was piloted as a paper tool in order to solicit honest feedback from users that would not be saved in EMR

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Tiered Monitoring Efforts Instill Accountability

Phased Bundle Adherence Accountability

Stages of the Sepsis Bundle Accountability Strategy at Wake Health

**Executive Follow-Up on 100% of Cases**
- Review every sepsis case for bundle compliance
- Associate CMOs call all involved physicians to either congratulate compliance, or uncover causes of non-compliance
- Every clinician receives feedback regarding case

**Performance Email to Clinicians**
- Every relevant physician receives email detailing compliance and is invited to respond with reasons for non-compliance

**Compliance Tracking for 50% of Cases**
- System reviews 50% of sepsis cases for bundle compliance
- RRT nurses monitor and report on non-compliance and challenges

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1) For example, nurse notified whether or not they appropriately triggered sepsis alert according to high Early Warning Score.
Dear Dr. Zweig,

An audit conducted by Quality Assessment indicated that your patient met the criteria for Code Sepsis (EWS ≥ 8, 2 SIRS criteria and a potential source of infection), but Code Sepsis was not called and/or the sepsis bundle for floor patients was not completed. Some details are noted below:

(1) DELAY IN INITIATION OF ANTIBIOTIC THERAPY
(2) NO FLUID RESUSCITATION FOR ELEVATED LACTATE

Please help us continue to improve our care for potentially septic patients by responding to this email with the following:

1. Any information about bundle compliance that was not evident from the chart audit
2. Your clinical impression of the underlying cause of the patient’s high EWS if you think the patient did not have sepsis
3. Any system barriers that you encountered in the Code Sepsis process or in implementing the sepsis bundle
4. Recommendations for improvement in the management of patients with high EWS or sepsis

If you would prefer to discuss the case by telephone or in person, please indicate some times that would be convenient for you and the best way to contact you.

Thank You.
Cathy Jones
Associate CMO

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Recognizing Physicians for Bundle Adherence

CMO-Signed Email Reinforces Sepsis as Organization-wide Priority

Thank-You Email Template for Compliant Physicians

Thanks for your timely response to the CODE SEPSIS on [date]. This evidenced based care bundle is proven to be effective for patients presenting with signs and symptoms of severe sepsis. We appreciate your ongoing commitment to delivering the highest standards of patient care.

Russell M. Howerton, M.D., F.A.C.S.
Chief Medical Officer
Professor of Surgery

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Initiative Yields Across-the-Board Improvement

Improved Adherence to Care Standards

Rate of 100% Bundle Compliance, Including ABX within One Hour

<table>
<thead>
<tr>
<th></th>
<th>Pre-Initiative</th>
<th>Post-Floor Initiative</th>
<th>Post-Floor, ED, and ICU Initiative</th>
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<tbody>
<tr>
<td>Floor</td>
<td>13%</td>
<td>71%</td>
<td>84%</td>
</tr>
<tr>
<td>ICU</td>
<td>14%</td>
<td>79%</td>
<td>0%</td>
</tr>
<tr>
<td>ED</td>
<td></td>
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</table>

Time to Antibiotic Administration
In Minutes

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<th>Post-Floor, ED, and ICU Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor</td>
<td>396</td>
<td>53</td>
<td>29</td>
</tr>
<tr>
<td>ICU</td>
<td>427</td>
<td>63</td>
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<tr>
<td>ED</td>
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Improved Efficiency, Quality

Average Risk-Adjusted All Sepsis LOS Index Scores

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<th>Post-Floor Initiative</th>
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<tr>
<td></td>
<td>1.4</td>
<td>1.2</td>
<td>1.1</td>
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Average Risk-Adjusted All Sepsis Mortality Index Scores

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<th>Post-Floor Initiative</th>
<th>Post-Floor, ED, and ICU Initiative</th>
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<tbody>
<tr>
<td></td>
<td>1.49</td>
<td>1.25</td>
<td>.88</td>
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</tbody>
</table>

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.

Pre-Sepsis Initiative  Post-Sepsis Initiative
Key Takeaways for Sepsis Leaders

Dr. Jones’ Lessons Learned

1. Optimal sepsis care relies on a systematized, team approach (even if physicians know how to treat sepsis).

2. Approach non-adherence to the sepsis bundle as an opportunity to solicit feedback from clinicians on what barriers are standing in their way.

3. Getting clinicians comfortable with giving antibiotics to patients without confirmation of infection is a significant challenge, but critical to ensuring timely antibiotic administration.

4. Senior leadership involvement is a must to signal organizational commitment and promote accountability.

5. The initiative was harder than Dr. Jones initially estimated. Sepsis initially seemed like a “slam dunk” since guidelines exist. But, there was a lot of education, logistics, and performance tracking that needed to happen to transform sepsis care delivery.

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
Questions?

Dr. Cathy Jones, MD, MS
Wake Forest Baptist Health
Associate Chief Medical Officer

Megan Zweig
Physician Executive Council Consultant
202-266-5416
ZweigM@advisory.com

Source: Wake Forest Baptist Health, Winston Salem, NC; Physician Executive Council interviews and analysis.
What Did You Think of Today’s Session?

Please take a minute to complete our evaluation.

• Once you or the presenter exits the webconference, you will be directed to an evaluation that will automatically load in your web browser.

• Please take a minute to provide your thoughts on the presentation.

Thank you!