

#### Infection Prevention, Antimicrobial Stewardship and Rapid Response in Southern Middle Tennessee SNF (**IPASRR**)

Maury Regional Medical Center 11 Skilled Nursing Facilities Award: \$928,878.07 (over 3 years) Jill Gaddes, MSN, RN, CNML Theresa Harris, MSN, RN, CCRN, CNE, ACCNS-AG

# Pop Health Framework

HeatthRecord

Primary Care Systems Design Patient as Partner Patient as Partner

High Value Network (CIN/ACO)

Patient as Partner Person/Provider Relationship High-Value Network Care Coordination Primary Care Systems Design Enabling EHR Telehealth/Patientfacing tech Contracts & Outcomes: Persons served Community well-being

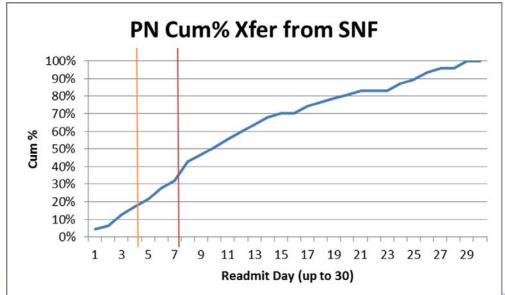
# Drivers

 623 patient readmissions at Maury in calendar year 2017 (27.6% of the 2,250 inpatient or observation encounters after which Maury discharged patients to SNF or swing beds).



# Drivers

- Higher than expected SNF readmission rate after an initial episode of pneumonia, for which sepsis was the most frequent readmission cause.
- 25% of SNF readmissions happen within 4.5 days; & 50% within just over seven days of index discharge





# Drivers

 53% of inpatient SNF Admissions occur between 6:00PM and 7:00AM (twelve months ending June, 2018). SNFs report difficulty obtaining in-person provider observation and assessment, resulting in transport to the Emergency Department.



### Interventions **①**

 SNF-based coordinator focused on infection prevention, education and surveillance – will conduct intensive observation and assessment to identify contributing factors and engage SNF leaders in their remedy. Education (virtual and in-person) will raise awareness and knowhow related to early identification and goal-directed therapy for healthcare associated infections.

### Interventions **2**

 SNF-based pharmacist to assist SNF providers with antimicrobial stewardship. The clinical pharmacist will monitor antibiotics prescribed for residents on admission & at least weekly and communicate with providers and facility pharmacists regarding antibiotic management.

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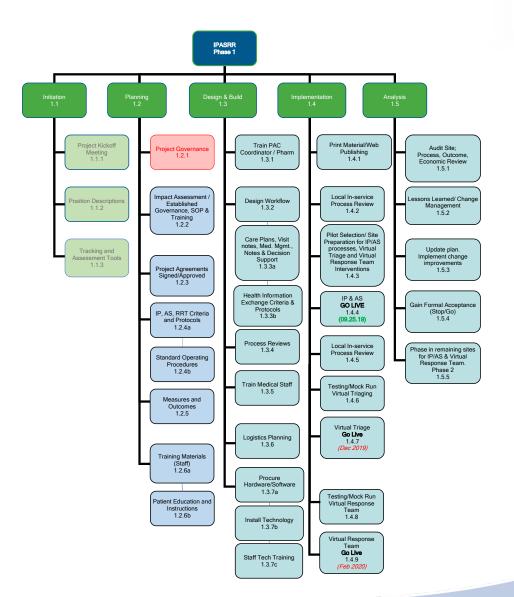
 Deploying a novel rapid response team (RRT) capability via virtual technology to assist local SNF caregivers assess and manage patients' deterioration. A SNF call, alerting the RRT of patient concerns, will prompt a "virtual" assessment followed by appropriate protocol-driven therapy. By treating in place, we hope to reduce rehospitalizations of shared patients.

# **Project Stakeholders**

- VP Population Health
- Director, Population Health & Care Coordination
- PAC Education Coordinator
- Director, Infection Prevention
- Nurse Manager, Critical Care
- Administrative Director, Cardiovascular Services
- Telemedicine Manager
- Director, Nursing Professional Development/Magnet
- Infectious Disease Pharmacist
- SNF Administrators and Project Designees

#### Work Plan





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#### Timeline

March-19	April-19	May-19	June-19	July-19	August-19	September-19	October-19	November-19	December-19	January-20	February-20	March-20	April-20	May-20	June-20	July-20	August-20	September-20	October-20	November-20	December-20	January-21	February-21	March-21	April-21	May-21	June-21	July-21	August-21	September-21	October-21	November-21	December-21	January-22	February-22	March-22	April-22
Jul	-Sep																																		_		
1.		ectic						-			virtu	al c	aret	echr	nolo	gies																					
2.		evelop Project Protocols and Metrics																																			
3.		Data mining to extrapolate which patients will be selected for the program																																			
4.	-	Logistic Planning of sites (phasing sites-first, second, etc.)																																			
Wł	Who: Telemedicine Manager, Vendor, Contracting, Compliance Officer, Quality Management, Lead IT specialist																																				
	_	Sep-Nov																																			
	_	1. Training clinical and support staff																																			
		2. Market virtual care services																																			
	Who: Telemedicine Manager, Vendor, Marketing, Quality Management, People Development, Nurse Educator																																				
	Nov-Jan																																				
	-	1. "Go Live" with high risk patients with Chronic Heart Failure (CHF).         When Amely Lange Manager Manager Manager Ling kts																																			
	-	Who: Ambulatory Care Manager, Maury Home Health, Telemedicine Manager, Admin. leadership															_																				
	Mar-May														_																						
	1. "Go Live" with high risk patients with Chronic Obstructive Pulmonary Disease (COPD).															_																					
	Who: Ambulatory Care Manager, Maury Home Health, Telemedicine Manager, Admin. leadership May-Jul														-																						
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Who: Ambulatory Care Manager, Maury Home Health, Telemedicine Manager, Administrative leadership, Quality Management         Outcomes Assessments       CHF 6m       CHF 12m       CHF 18m       CHF 24m													-																								
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#### **Expected Successes**

- Improve Overall Outcomes for Shared Patients
- Reduce unnecessary ED visits and Readmissions to Acute Care
- Produce Value for PACN
   Sharing Resources and Protocols
- Professional Development for SNF Staff
- Continuity of Care Across Continuum

#### Questions

