



MAURY REGIONAL  
HEALTH

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

Maury Regional Medical Center

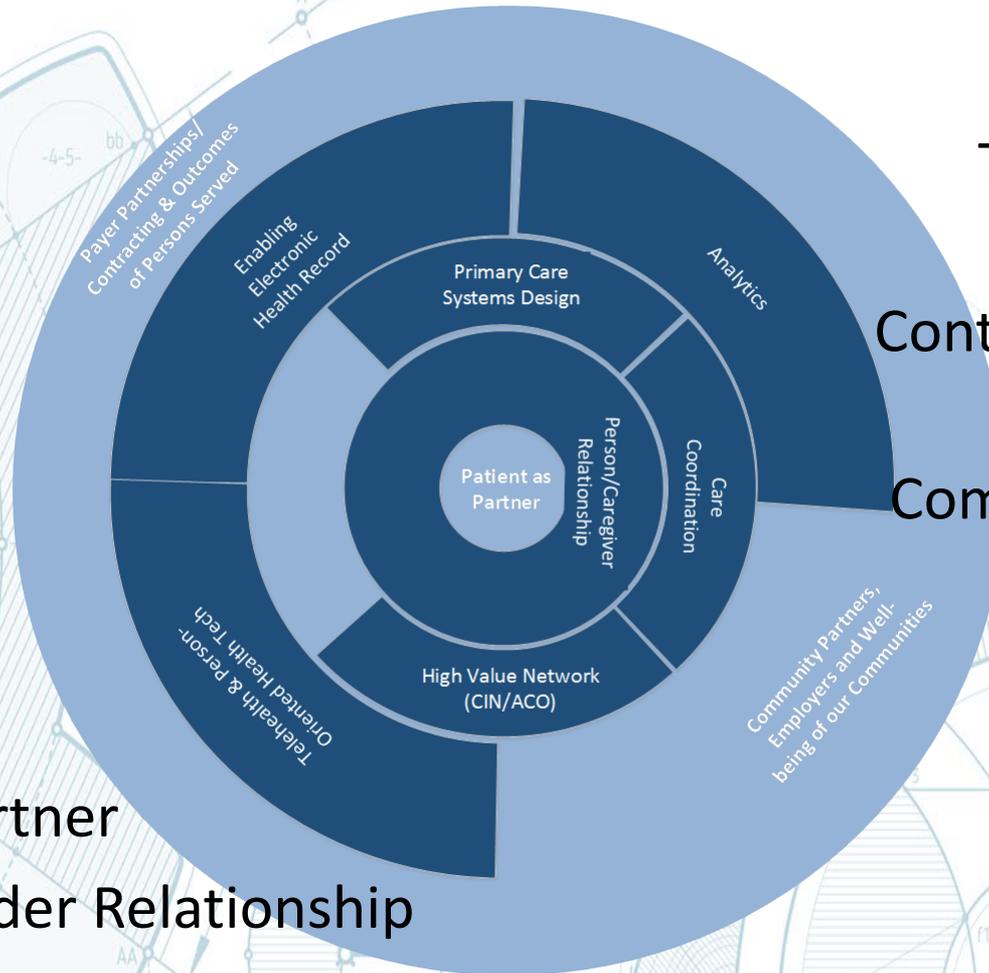
11 Skilled Nursing Facilities

Award: \$928,878.07 (over 3 years)

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# Pop Health Framework



Enabling EHR  
Telehealth/Patient-  
facing tech

Contracts & Outcomes:  
Persons served  
Community well-being

Patient as Partner

Person/Provider Relationship

High-Value Network

Care Coordination

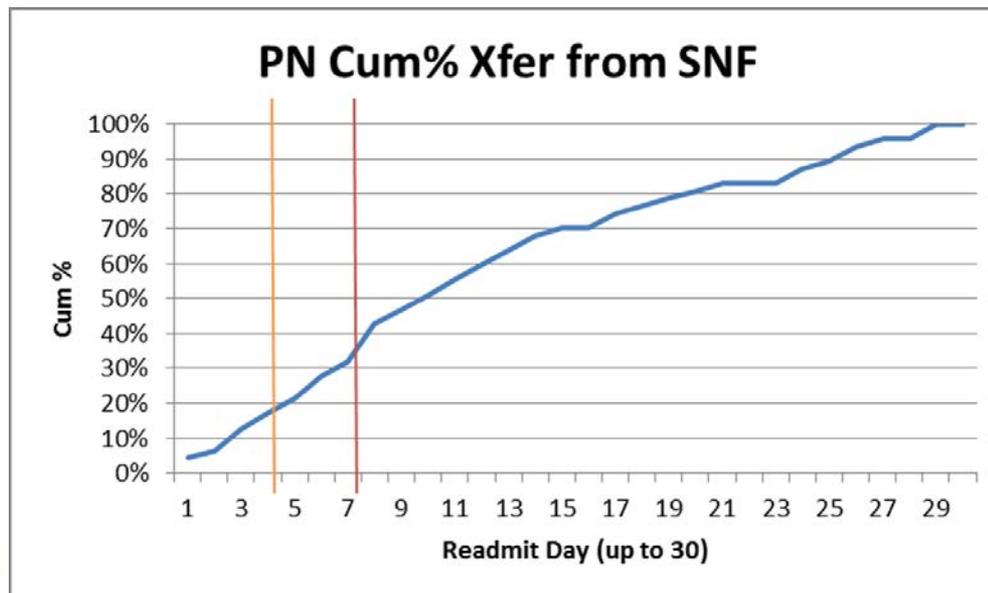
Primary Care Systems Design

# 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.

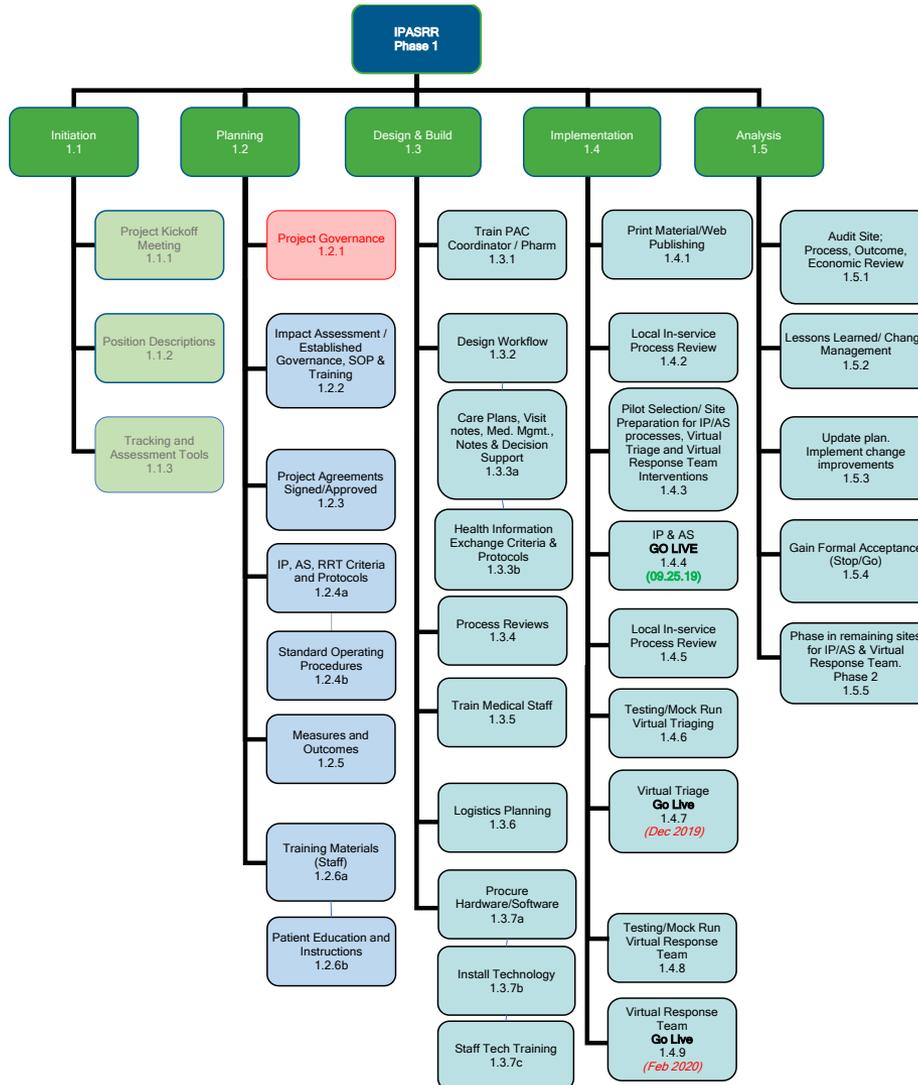
# Interventions ③

- **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 re-hospitalizations 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





# 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

