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How Novant cut sepsis mortality in half — and why it's calling for policy change

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By: **Mackenzie Bean** 5 hours ago

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Novant Health has achieved a more than 50% reduction in sepsis mortality across its hospitals since 2021, following coordinated efforts to improve early identification and treatment.

The Winston-Salem, N.C.-based health system attributes this improvement in large part to its continued use of the Sepsis-2 criteria, which emphasize early, symptom-based detection.

Although payers are increasingly aligned with Sepsis-3 — a 2016 framework centered on life-threatening organ dysfunction — Novant has found that such criteria often delay intervention. By maintaining Sepsis-2 protocols, the health system has seen measurable gains in patient outcomes.

Daniel Feinstein, MD, system physician executive for the Novant Health Hospital-Based Medicine Institute and co-director of systemwide sepsis care, recently spoke with *Becker's* about these clinical advancements and the policy shifts needed to improve sepsis care at the state level.

Editor's note: Responses have been lightly edited for length and clarity.

Question: Novant Health has reported significant improvements in patient survival rates using the Sepsis-2 criteria. Can you share more about the system's decision to stick with Sepsis-2?

Dr. Daniel Feinstein: The Sepsis-3 criteria came out in 2016 and were really touted as the new and improved quick assessment meant to facilitate early diagnosis. But in the end — and within our literature in medicine, critical care and hospital-based medicine journals — we found that Sepsis-3 criteria really reflect the terminal- or end-stages of sepsis. When someone has mental status changes, is breathing fast or their blood pressure is low, that's someone who's already very advanced in their sepsis event. That doesn't help us much, since it's so important to treat fast, which means identifying early. The Sepsis-2 criteria allow us to cast a wider net and identify patients early in their sepsis care.

To take 20-plus hospitals and a bunch of clinicians and make changes as dramatic as we have is really remarkable. We've seen a greater than 50% reduction in mortality for sepsis patients.

We use scoring systems to predict survival, and we found that, because of this work and using Sepsis-2 criteria for early identification, about 25 to 26 patients per month who were predicted not to survive their sepsis event are now surviving across the system. That's a testament to the collaboration and hard work. It all starts with identification — and with the proper definition.

Q: What steps did you take at the system level to achieve early sepsis identification and consistency across hospitals?

DF: Over the past several years, our system — all of our facilities working together with leaders and specialties involved in sepsis care — has fine-tuned processes, order sets and triaging.

We focused heavily on triage. The second a patient comes through the emergency room, they're screened immediately. If they screen positive, they're brought to the clinical team without delay. We also emphasized rapid source control. For example, if someone needs surgical intervention for a perforation, they get it right away.

Another big piece was creating a live data dashboard. This lets us monitor whether patients are getting the sepsis bundle elements (blood cultures, lactate levels, antibiotics, fluids) within the three- and six-hour windows. That level of accountability improved compliance and outcomes.

Q: Beyond definitions, what role do technology and innovation play in how Novant is advancing sepsis care?

DF: We use best practice advisories in the EHR to flag patients meeting Sepsis-2 criteria. When certain clinical factors align, the BPA alerts the clinician and initiates the sepsis bundle process.

We also use Epic's Sepsis Analytic Screening Tool, which runs in the background to predict who's at risk for developing sepsis. When a patient's score crosses a threshold, it alerts our rapid response team and bedside nurse to intervene before decline.

One of the things I'm most proud of is our use of virtual care services in sepsis management. We employed tele-ICU physicians and nurses to follow up with bedside providers to ensure they are meeting bundle requirements when a BPA is triggered.

Within three months of implementing that [in 2020], we saw a 30% improvement in bundle compliance. Our tele-ICU providers now touch over 5,300 patients a year across the system. Over the course of my career, I've seen as much as a 25% reduction in patients who would have gone to the ICU because we assisted, and were able to get them fluid and antibiotics as fast as possible.

Q: Payers often rely on Sepsis-3 criteria, which can sometimes delay or deny coverage, while clinicians emphasize early intervention. How has Novant Health navigated these competing priorities?

DF: As physicians, the last thing we need to worry about is the payer's definition of sepsis. Payers should rely on clinicians and medical literature. We need to cast a wide net, use Sepsis-2 criteria, and treat patients early and fast.

Our clinicians and advanced practice providers feel very supported by Novant and our Center for Public Policy Solutions, which has issued a [white paper](#) outlining how legislation mandating standardized sepsis protocols

in states like [New York](#) and [Kentucky](#) are saving lives. The organization has said, “What’s best for patients is best for patients.”

They trust our clinical know-how and have fully supported our decision to use Sepsis-2 as the best criteria for early identification and treatment. There’s been zero financial pressure from Novant — just trust in our ability to provide the best care.

Q: What final thoughts would you like to share about advancing sepsis care in North Carolina and beyond?

DF: North Carolina has high volumes of sepsis, and our outcomes could be better compared to other states, likely due to its rural nature and other economic disparities. We should recognize that North Carolinians are at a disadvantage because of that.

North Carolina has an opportunity to do the first and most important step, which is mandating a single sepsis definition. Let’s get rid of the concerns about payers and other people having a different definition. We really need to get to them early and fast, and we need governmental policy to help us along.



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