Australian Commission on **Safety and Quality** in Health Care

ARTD CONSULTANTS

Coordination of care and post-sepsis support

Business Case

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Preface

On 13 September 2019, the Hon Greg Hunt MP announced $1.5 million in funding, to support improved sepsis outcomes. The Commission established the National Sepsis Program in June 2020 under a contract for services with the then Department of Health, Disability and Ageing.

Priorities for coordinated national action on sepsis were identified through consultation with The George Institute for Global Health (TGI), state and territory health departments, sepsis clinical experts and healthcare organisations.

These priority areas formed the basis of the program's key objectives, which included:

- Improving the recognition of sepsis in all healthcare settings
- Providing healthcare professionals with nationally agreed sepsis clinical guidance materials
- Strengthening the comprehensive care planning process for sepsis survivors.

The Commission, in partnership with TGI delivered eight discrete projects including in 2022 the launch of the first National Sepsis Clinical Care Standard.

The 2022-23 Budget provided a further $2.1 million to continue a focus on improving sepsis recognition and response. The Department engaged the Commission in partnership with TGI to deliver the National Sepsis Program Extension between 2023 and 2025.

The Program Extension is made up of five additional projects:

1. Targeted national public awareness campaign
2. Education and training resources for healthcare professionals
3. Coordinated sepsis care and post sepsis support for survivors and families.
4. Data collection tools for quality improvement
5. Improving recognition of sepsis in First Nation peoples.

Aim

Project three aims to provide greater information and clarity for consumers, their families and healthcare professionals about options and pathways for high-quality evidence-based post-sepsis care.

The Commission contracted ARTD consultants to develop a Business Case to provide the strategic and economic rationale for investment in care coordination and post-sepsis support.

ARTD conducted research and analysis and consulted with sepsis survivors, families and health workers to develop this Business Case. It highlights how investment in sepsis coordination and post sepsis support aligns with the delivery of the National Health Reform Agreement and can contribute to the reduction in avoidable readmissions thereby reducing the cost of sepsis on health care systems and society.

Business Case

Rationale for investment in coordination of care and post-sepsis support

Contents

1. Snapshot

Conservative estimates of the costs of activity-based funding (ABF) for public hospital separations for sepsis survivors are **over $3.7 billion AUD per annum** in 2025/26 (Table 1).

Evidence from a care coordination and post-sepsis support program in the US shows that a close to 8% reduction in hospital readmissions is achievable. Achieving this reduction in Australia would create an estimated **saving of $100 million AUD** in ABF each year (Table 3). This provides a strong economic rationale for investment. Evidence indicates that investments would also create **other cost-savings and funding opportunities**, however these cannot be quantified with available data.

Investment in coordination of care and post-sepsis support aligns with implementation of the Sepsis Clinical Care Standard, and can create cost-savings that are likely to fully offset or exceed the costs.

The theory of change (Figure 1) and cost-savings table (Table 2) illustrate how cost-savings can be achieved, in alignment with the quintuple aim of healthcare: improving the health of populations, enhancing the patient experience of care, reducing the per capita cost of health care, improving the work life of healthcare providers, and advancing health equity.[1]

Figure 1 Theory of change

IF WE

Provide access to coordinated care and post-sepsis supports

Address gaps in education and training about sepsis and post sepsis syndrome

WE CAN ACHIEVE

Early recognition and treatment of sepsis and post-sepsis syndrome

Coordination and collaboration through transitions of care

Improved communication between consumers and medical professionals

LEADING TO

Improved understanding of and adherence to medical advice after discharge

More efficient and effective use of primary health

Reduced preventable hospitalisations

Reduced trauma for bereaved family members

OVER THE LONGER TERM CREATING

Faster recovery times and outcomes

Improved health, wellbeing and socio-economic outcomes

Reductions to the costs of providing health care.

2. Introduction

Health services across Australia are implementing the Sepsis Clinical Care Standard (2022) to improve sepsis prevention, recognition and response. The Standard provides national clinical guidance to support health providers improve early recognition, treatment, outcomes and post-discharge support for people at risk of, or diagnosed with, sepsis in Australia. Quality Statements 4-7 (QS 4-7) of the Standard focus on coordinated in-hospital care, patient and carer education and information, transitions of care, and care after hospital and survivorship.

A **model of care framework for sepsis care coordination and post-sepsis support** has been developed to guide health services across Australia as they implement the Sepsis Clinical Care Standard (2022). This document provides the economic rationale for investment in sepsis care coordination and post-sepsis support.

Investment in coordinated care and post-sepsis supports align with implementation of the Standard, and supports delivery of the **National Health Reform Agreement**[2] goals:

- **delivering safe, high-quality care in the right place at the right time** by moving towards integrated services that address the gaps, improve the quality of care and support transitions between hospital and community care
- **prioritising prevention** by providing ongoing education for medical professionals, to ensure sepsis is recognised and treated early in its progress, and consistently providing preventive health information for sepsis survivors, families and carers
- **helping people manage their health across their lifetime** by improving information, connection and referral for sepsis survivors, families and carers, and improving bereavement support
- **driving best-practice and performance using data and research** by improving the accuracy of sepsis coding, investing in ongoing education for medical professionals, improving visibility of patient outcomes after discharge from hospital, and monitoring and evaluating investments into coordination of care and post-sepsis support
- **improving efficiency and ensuring financial sustainability** by reducing avoidable readmissions, improving patient outcomes, and reducing health impacts and the cost of healthcare over the lifespan.

This Business Case provides the economic rationale for investment in coordination of care and post-sepsis support and is supported and accompanied by a:

- **Model of Care Framework**
- **Supporting Evidence and Implementation Ideas document.**

These resources can be found on the Commission's website.

2.1 Sepsis costs Australia more than $3.7 billion a year

There are an estimated 93,000* separations of sepsis survivors from Australian public hospitals each year, and over 11,000 in-hospital deaths are caused by sepsis annually.[3] The National Sepsis Program Extension Epidemiology Report[3] highlights that in 2022-23:

- 3 in 4 separations were emergency admissions
- 21,000 were readmissions within 30 days (over 50% of total readmissions)
- the average length of hospital stay was 13 days
- 1 in 4 were admitted to ICU (27.8%)
- 1 in 8 developed a hospital acquired complication (HAC)
- 1 in 7 sepsis cases resulted in a hospital death.

Conservative† estimates put the costs of activity-based funding (ABF) for public hospital admissions at **over $3.7 billion AUD per annum** in 2025/26 (Table 1). This does not include readmissions, the costs of addressing health and wellbeing needs of survivors, families and carers over the longer-term, nor people bereaved by sepsis.

Consultations with health stakeholders and consumers, and available literature consistently identify that the lack of coordinated care (including coordinated and ongoing education for medical professionals), and post-sepsis support contribute to these costs through:

- delayed recognition and treatment, leading to poorer patient outcomes[4]
- delayed or no treatment of post-discharge health issues caused by sepsis[5]
- emergency department presentations and readmissions for preventable causes[6]
- lack of support for traumatic bereavement (associated with higher healthcare costs over the lifespan)[7]
- ineffective primary care due to lack of sepsis diagnosis on discharge summaries, or long delays in discharge summaries being received[8]
- lack of appropriate information provided to consumers to support adherence to care instructions and self-care.[9]

* This is an extremely conservative estimate based on data from public hospital cases with explicit sepsis codes (which are not always accurately applied), which does not include sepsis cases in private hospitals, or presentations to emergency departments (prior to public hospital admission).

† As above.

Table 1 Estimates of ABF expenditure on sepsis

	Number of patients	Estimated cost per patient (2022-23)	Estimated total cost 2022-23	Total estimated cost 2025-26*
Sepsis separations (2022-23)	84,382	$31,440	$2,652,970,080	$3,316,212,600
Sepsis readmissions (30 days)	21,434	$17,954	$384,826,036	$481,032,545
Separations and readmissions			**$3,037,796,116**	**$3,797,245,145**

Note: Cost estimates uses separations and cost estimates from 2022-23 year from Table 8 of the Australian Commission on Safety and Quality in Health Care 2025 Epidemiology Report.[10] Total estimated cost for 2025-26 applies a 25% increase to the 2022/23 figures: the amount which the NWAU has increased between 2022/23 and 2025/26. [11]

2.2 Investment in coordination of care and post-sepsis support will reduce costs

The costs of sepsis to the Australia's healthcare system can be reduced through improved coordination of care for people experiencing sepsis and better post-sepsis support.

Approaches to coordination of care are beginning to emerge in Australia, with a handful of known models. There are even fewer examples of post-sepsis support models, with one known follow-up care model at the Perth Children's Hospital (operating since April 2025). Currently there is insufficient data to quantify many of the potential cost-reductions associated with implementing these programs.

The **Supporting Evidence and Implementation Ideas** companion document outlines the literature and views of sepsis survivors and health stakeholders. These strongly support the rationale that the long-term benefits of resourcing roles in sepsis care coordination and post-sepsis support, will ultimately equal or outweigh the costs.

Table 2 Indicative estimates of cost-savings and resourcing costs

Potential cost-savings and funding	• Indicative estimated savings between **$912,000 and $34 million** for states/territories if an 8% reduction in readmissions is achieved (Table 4). • Avoided loss of ABF due to inaccurate sepsis coding - for example, the difference in weighting between viral illnesses,

	major complexity (6.5) and sepsis, septic shock and systemic infection, major complexity (13.6) is a difference of **$51,532 per *patient*** in ABF, or a **$8,709 *per patient*** difference for minor complexity cases.[12] Potential ABF earnings for follow-up care delivered in an outpatient setting (in PCH's first month of operating paediatric outpatient follow-up, an average of 7.25 patients a week were seen, generating $1,614 in ABF per week.[13] Should this trend continue, it would generate **$83,928 in ABF per year**). • Reduced loss of ABF due to avoidable readmissions (a risk-adjusted reduction of between 100% and 40.9% is applied to the index episode, based on the total price of the associated readmission). • Reduced health impacts and cost of healthcare over the lifespan for people bereaved by sepsis, including children. • Improved sepsis recognition and time to antibiotics, leading to improved patient outcomes (reduced cost of treating sepsis sequelae). • Improved antimicrobial prescribing, leading to patient outcomes (reducing treatment costs and risk for readmission). • Improved capability of primary health providers and patients to manage care.
Estimated costs of resourcing	• Sepsis coordinator models currently in place are estimated to cost between **$78,000 and $318,000 AUD**, dependent on staff FTE required to support patient load and whether the model includes post-sepsis follow-up (Table 5, Table 6).

Reduction in avoidable readmissions reduces costs to the healthcare system and society

Patients who have been hospitalised with sepsis have high readmission rates. An Australian study found around half of all patients who had been hospitalised with sepsis were readmitted to hospital within 90 days and that more than 70% were readmitted within a year.[14] For about 20% of cases in the same study, readmission within a year of their first sepsis hospitalisation was for sepsis recurrence. Some of these readmissions are avoidable.

The US-based Sepsis Transition and Recovery (STAR) program, which provides transition and post-sepsis care for adult patients, delivered an almost 8% decrease in re-hospitalisations for sepsis survivors.[15]

Tables 3 illustrates the estimated national savings for an 8% reduction in 30-day and 12-month readmissions.

Table 3 Number of readmissions avoided and National cost-savings at 30 days and 12 months from hospitalisation with an 8% reduction in readmissions

	Number of readmissions avoided	National cost savings
8% reduction in 30-day readmissions	1,715	$38,482,603
8% reduction in admissions over 12 months	4,725	$106,051,973

Note: Cost estimates use 2022-23 patient 30-day readmission and cost data from Table 8 of the Australian Commission on Safety and Quality in Health Care 2025 Epidemiology Report ($17,954 per readmission), plus 25% representing the increase in NWAU between 2022-23 and 2025-26 ($22,443 per readmission). Reduction over 12 months assumes rate of 70% re-admissions within a year, applied to 2022-23 patient readmissions data.[16]

Indicative estimates of cost-savings for each state and territory (based on the proportion of Australia's public hospitals based in each state) also show the potential for millions in savings (Table 4).

Table 4 Indicative savings for public hospitals by state if 8% reduction is achieved

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Number of hospitals per state[17]	223	158	123	88	75	24	3	6
Proportion of total Australian hospitals in each state/territory	31.86%	22.57%	17.57%	12.57%	10.71%	3.43%	0.43%	0.86%
Estimated savings by state/territory from 8% reduction in readmissions	**$33,788,158**	**$23,935,930**	**$18,633,331**	**$13,330,732**	**$11,358,166**	**$3,637,582**	**$456,023**	**$912,046**

Cost estimates use 2022-23 patient 30-day readmission and cost data from Table 8 of the Australian Commission on Safety and Quality in Health Care 2025 Epidemiology Report ($17,954 per readmission), plus 25% representing the increase in NWAU between 2022-23 and 2025-26 ($22,443 per readmission). Reduction over 12 months assumes rate of 70% re-admissions within a year, applied to 2022-23 patient readmissions data.[18]

Avoidable readmissions also have repercussions for hospitals' ABF. When patients are readmitted for issues clinically related to the index admission, a risk-adjusted reduction is applied to the index episode, based on the total price of the associated readmission.[19] This means that hospitals are bearing more of the financial risk of avoidable readmissions. A reduction in avoidable rehospitalisation due to unresolved infections or new infection would increase the ABF hospitals are paid per treatment episode, as well as reducing the overall cost to the health care system and to patients themselves.

More accurate capture of sepsis patients enables more accurate ABF payments

Consultations with the healthcare sector highlighted that sepsis codes are not always well applied. These views are consistent with a medical record review, which recommended further exploration of coding variation and the need for more strategies to improve clinical documentation of sepsis and suspected sepsis.[20] ABF relies on clear documentation and accurate coding. Improving the quality of documentation of sepsis will improve the quality of coding and capture of sepsis related activity, leading to more accurate ABF payments.

Education for clinicians on good documentation and support for clinical coders to become familiar with health information systems are strategies known to improve the quality of data used to inform ABF payments. Engagement between clinical leaders and clinical coders also supports better data quality. Together these strategies may also strengthen sepsis awareness and reinforce the use of clinical pathways.

Documenting sepsis leads to better health outcomes

Health stakeholders identified a lack of alerts or flags about a sepsis diagnosis in many patient records systems. Information management systems should support clinical decision-making and communication. Documenting the activation of a sepsis pathway and recognition of a deteriorating patient can improve the quality of current and future clinical care as well as supporting more accurate capture and coding.

2.3 Costed examples of sepsis coordinated care and post-sepsis support models

Estimated costs from known sepsis programs and sepsis coordinator roles around Australia are provided in the tables below (see Table 5 and 6). When considered with available data on potential cost-savings, it indicates that investment in coordination of care and post-sepsis support can be cost effective.

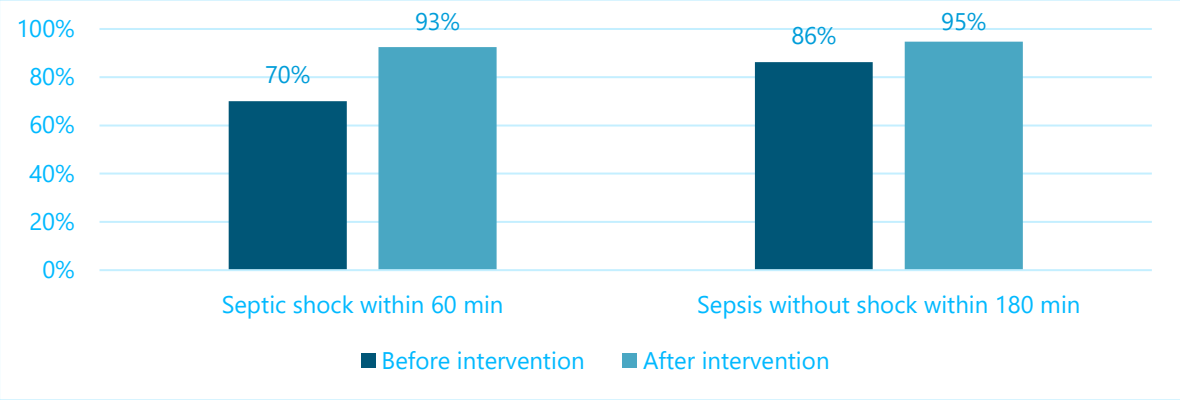
Case Example: Perth Children's Hospital

Perth Children's Hospital instituted a Paediatric Sepsis Coordination team in August 2022. The team through the first year of implementation included 0.2FTE Clinical Lead, 1FTE Sepsis

Clinical Nurse Consultant and 0.4 FTE administrative support. Team responsibilities included implementation of a sepsis pathway, sepsis education and training data collection and analysis. After one year the team reported:

- a reduction in the median time from recognition to antibiotic administration
- a significant increase in the proportion of patients who received antibiotic therapy within recommended timeframes[21] (Figure 2).

Figure 2 Increase in proportion of patients who received antibiotic therapy within recommended timeframes at Perth Children's Hospital



Source: McCarthy B, Middleton N, Gill F, Goff Z, Paterson Z, Blyth C (2025) 'Impact of an evidence-based sepsis pathway on paediatric hospital clinical practice: a quality improvement study', Emergency Medicine Australasia, 37. Pg. 1

In April 2025, PCH began a pilot nurse-led outpatient patient-follow up program, with the addition of a 0.6FTE Clinical Nurse. The pilot targets patients who have hospital stays longer than 7 days (approximately 100 of the 500 paediatric patients treated for suspected sepsis each year). In the first month, there were 7.25 service events, generating $1,613.90 per week.[22] The pilot is being evaluated and with further data and results expected in the latter half of 2026.

Table 5 provides an example of resourcing and salary costs that could be expected for a similar sepsis coordination team.

Table 5 Resourcing: sepsis coordination team

Role	Upper range of average salary[16]	FTE	Cost of time
Clinical nurse	$115,000	0.6	$69,000
CNC	$140,000	1	$140,000
Physician	$250,000	0.2	$50,000

Role	Upper range of average salary[16]	FTE	Cost of time
Administration officer	$65,000	0.4	$26,000
Total salaries		2.2	**$285,000**
Total including superannuation (11.5%)			**$317,775**

Case example: Think Sepsis Scaling Collaboration

The 'Think Sepsis. Act Fast' Scaling Collaboration was a 12-month project undertaken by Melbourne Health to implement a sepsis pathway and multidisciplinary education package across 11 health services. The project invested in personnel to resource the work of:

- embedding a sepsis pathway
- delivering multidisciplinary education
- engaging consumers in the management of sepsis.[23]

There were significant economic benefits and patient outcomes delivered.

Table 6 Resourcing costs and benefits of Think Sepsis Scaling Collaboration

Resourcing	Cost	Benefits
• 12 Clinical leads (total 1.3 FTE) • 12 Project leads (total 9.8 FTE) • 1 Database manager (total 0.2 FTE)	$1,845,230	**Economic** • $11.7 million[‡] savings (from reduced length of stay and reductions in cost of ICU) • cost savings of $6,654 per patient **Patient outcomes** • 50% decrease in mortality • 34% decrease in initial ICU admissions and 51% decrease in further ICU admissions during the same episode • 1.2-day decrease in mean ICU length of stay and 0.1-day reduction in median length of stay • 2.9-day reduction in mean total length of stay and 1.4-day decrease in median total length of stay

[‡] This does not include the estimated costs of the 52 lives it was estimated were saved during the implementation period, which were estimated at $371.8 million[24]

Resourcing	Cost	Benefits
		• 73.1% improvement in adherence to the sepsis pathway.

Source: Safer Care Victoria (2019) Think sepsis. Act fast: Scaling collaboration program evaluation 2017–18. Victorian Government.Pg. 5, 9,16; Brusco N, Sykes K, Cheng A, Radia-George C, Travis D, Sullivan N, Dinh T, Foster S, Thursky K (2023) 'A state-wide implementation of a whole of hospital sepsis pathway with a mortality based cost-effectiveness analysis from a healthcare sector perspective', PLOS Global Public Health 3(5)

This example also shows the benefits of delivering improvements to the management of sepsis care at scale, as toolkits, the education package and communication materials were prepared by Melbourne Health and then utilised across all sites, reducing duplication of effort, and freeing up project officer time to focus on implementation.

This example represents only a few of the elements that are needed to deliver improved coordination of care and post-sepsis support, and is inclusive of sepsis pathway implementation, however, this approach illustrates the kind of value that can be achieved through resourcing specific roles for sepsis processes, education, management and consumer engagement.

A more detailed case study of this project is highlighted in the **Supporting Evidence and Implementation Ideas document**.

Resourcing examples from other existing models

Consultations with health stakeholders also identified several other single or joint coordinator models being tried across Australian jurisdictions. Estimated costs are provided in Table 6. These models do not include responsibilities for post-sepsis support.

Table 7 Other estimated costings based on existing examples within Australia

Role/s	FTE	Estimated cost (incl super 11.5%)	Responsibilities (at time of interview, early 2025)
Registered Nurse	1	$106,000	• Responsible for 1 tertiary hospital (600 beds) • Outreach and education to primary care and community care facilities • Promotion of sepsis information to public

Role/s	FTE	Estimated cost (incl super 11.5%)	Responsibilities (at time of interview, early 2025)
			• Mapping available post-sepsis care services • Surveillance of the sepsis programme, monitoring and data reporting • Patient-facing role in coordination
Clinical Nurse Consultant	0.5	$78,000	• Responsible for 5 sites (a 200-bed hospital, a rural facility, a corrections facility and 2 satellite hospitals) • Education on sepsis pathways • Data collection and monitoring for quality improvement supporting tool development for use in corrective services • No patient-facing role in coordination
Nurse Practitioner, Clinical Nurse Specialist	0.6 + 0.3	$142,000	• Responsible for specialty hospital (200 beds) • Patient assessment to support sepsis pathway when requested utilising the Sepsis Clinical Care Standard Discharge planning tool • Delivers mandatory training on sepsis pathway • Provides patient information sheets • Monitoring data • Patient-facing role in coordination
Paediatric Clinical Nurse Consultant	1	$156,000	• Education for staff across 16 hospitals[25] • No patient-facing role in coordination

Source: SEEK (2025) Administration Support Officer Salary in Australia (May, 2025), Clinical Nurse Consultant Salary in Australia (May, 2025), Clinical Nurse Salary in Australia (May, 2025), Clinical Nurse Specialist Salary in Australia (May, 2025), Nurse Practitioner Salary in Australia (May, 2025), Physician Salary in Australia (May, 2025) – SEEK, Registered Nurse Salary in Australia (May, 2025), SEEK website, accessed 1 May 2025.

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