

Coordination of care and post-sepsis support

Supporting evidence and implementation ideas

ARTD Consultants, Sydney (Eora), Melbourne (Narm) and Brisbane (Meanjin), prepared this report on behalf of the Australian Commission on Safety and Quality in Health Care

Published by the Australian Commission on Safety and Quality in Health Care

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Website: safetyandquality.gov.au

ISBN: 978-1-923353-32-9

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Australian Commission on Safety and Quality in Health Care. National Sepsis Program Extension, Sepsis Care Coordination and Post Sepsis Support, ACSQHC; 2025.

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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 Australian Commission on Safety and Quality in Health Care (the Commission) established the National Sepsis Program in June 2020 under a contract for services with the then Department of Health and Aged Care.

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 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 evaluate the implementation of care coordination and post sepsis support in health care services and define key elements of an effective model of care to strengthen coordination of post sepsis information and support, including bereavement support.

ARTD consulted with sepsis survivors, families and health workers to develop a Model of care Framework and Business Case. This report is a companion document which describes how the model of care and business case were developed and outlines the evidence used to underpin statements and claims. It also provides case examples to illustrate how the model may be implemented.



Coordination of care and Post-Sepsis Support Model of Care Framework

*Supporting Evidence and
Implementation ideas*

Australian Commission on
Safety and Quality in
Health Care

July 2025



Acknowledgements



We also acknowledge the talent and artistry of Emma Walke, who designed the artwork for our acknowledgment of Aboriginal and Torres Strait Islander peoples. The design shows a story of connection to country and people, representing the breadth of work we do with Aboriginal and Torres Strait Islander communities across Australia. The colours represent the land, and the lines in between represent the water that connects us all.

This work was completed with the assistance of the National Sepsis Program at the Australian Commission on Safety and Quality on Health Care, and Dr Brett Abbenbroek, from The George Institute and Sepsis Australia.

We would also like to thank the many key informants from the hospital and health sector, as well as sepsis survivors, their families and carers, and people bereaved by sepsis. We thank them for their time and insights and trust that their views are adequately represented in this report.

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About this document

This document is a companion to the **Coordination of Care and Post-Sepsis Support Model of Care**, and the **Business Case**.

It shows how the model of care and business case were developed, and the supporting evidence used to underpin statements and claims. It also illustrates ways in which the model might be implemented.

Chapter 1 provides the background on the methods used to inform the Coordination of Care and Post-Sepsis Support Model of Care.

Chapter 2 provides evidence based on consultation from consumers, health stakeholders and evidence from the literature, of what needs to change and why. It includes a costed case story illustrating how current gaps in coordination of care and post-sepsis supports impact sepsis survivors, families and carers, and create additional costs to government.

Chapter 3 provides supporting evidence and rationale for investment in coordination of care and post-sepsis support.

Chapter 4 outlines how coordination of care and post-sepsis support might be funded and resourced, and the ways existing systems, models and tools could be leveraged.

Chapter 5 provides case examples from similar programs.

Appendices provide long alt-text descriptions and costing calculations and sources for the costed case studies.



Supporting evidence and implementation ideas



1. How was the framework developed?

The Coordination of Care and Post-Sepsis Support Model of Care Framework was developed following analysis, consultation and engagement to identify effective care coordination elements, systemic gaps, and opportunities for future sepsis care coordination and support.

The design phase included:

1. A review of existing literature on models of care for sepsis care coordination and post-sepsis support, other relevant integrated care models and evidence about the cost consequences of integrated models of care.
2. Surveys (n=390) focus groups (n=36) in 2024/2025. Respondents included health workers in hospital, governance, and community health-based roles. Results were summarised and discussed with the National Sepsis Program's National Oversight Committee and Commonwealth, State and Territory Liaison Group.
3. Consumer consultation to share the findings of health stakeholder consultation and develop ideas for the model of care. This involved:
 - a. a survey completed by 44 consumers
 - b. two focus groups (n=13) to map the sepsis patient journey, identify service gaps and opportunities supports along the journey, and test a set of care principles developed from the survey of consumers
 - c. semi-structured interviews with 7 people bereaved by sepsis.

The draft model was presented to consumers at the April 2025 Sepsis Australia Consumer Forum, and National Oversight Committee and State and Territory Liaison Group, with further refinements made.

2. Why do we need a sepsis coordinated care and post-sepsis support model of care?

2.1 The prevalence and severity of sepsis creates high social, emotional and financial costs

In 2022-2023 there were over 84,000 people admitted to Australian public hospitals with sepsis and over 12,000 in-hospital sepsis related deaths.¹ This is higher than has previously been estimated.² Also between 2022-23, one in 4 patients with sepsis was admitted to the ICU (28%), with an average ICU stay of 7 days.³ Of patients admitted to ICU for sepsis in 2023, 68 % required organ support and 6% needed inpatient rehabilitation after discharge.⁴ The length of hospital stay for sepsis patients is seven times as long as for non-sepsis patients, and rate of mortality is 11% higher than for non-sepsis patients.⁵

The high social, emotional and financial impacts of sepsis do not stop when a patient is discharged or dies from sepsis. It is common for affects to be felt by sepsis survivors⁶, their families and carers, and people bereaved by sepsis for years after hospitalisation.*

Estimates show approximately half of sepsis survivors continue to experience physical, cognitive and/or mental health problems even two years after discharge,⁷ including from acquired disabilities and post-sepsis syndrome. Around a third of paediatric sepsis survivors experience disabilities ranging from amputations to developmental delays or impairment.⁸ Patients who have had sepsis also have a rehospitalisation rate of 39% at one year after discharge,⁹ with infection being the most common reason.¹⁰

Sepsis survivors can experience a poorer health related quality of life for at least five years after discharge, and more than half of previously employed sepsis survivors experience an impact on their ability to work.¹¹

People bereaved by sepsis also experience long-term impacts on their emotional, mental and financial wellbeing.

* This was a common theme with consumers and people bereaved by sepsis who were consulted to inform the model of care.

2.2 Consumer experiences of the sepsis journey show the need

Conversations with people with lived experience of sepsis, and a range of health stakeholders identified systemic gaps impacting patient, family and carer outcomes, including people bereaved by sepsis. Key systemic gaps were information and communication, coordination of care at transitions, and ongoing professional development and education for health professionals. These align with international evidence that identifies two main barriers to achieving optimal sepsis care across the patient journey: professionals' lack of knowledge, and lack of communication between disciplines or sectors.¹²



Dismissal of patient and family/carer concerns delays diagnosis and treatment. Early recognition is essential to reduce preventable deaths and promote post-sepsis recovery.

In focus groups and survey responses sepsis survivors and people bereaved by sepsis consistently reported having concerns dismissed, or having the severity of their symptoms minimised by health professionals at initial presentation. One survivor described how difficult it was to get an ambulance to hospital, saying that she was not given priority despite being extremely unwell which meant that by the time she got to hospital she was in a critical condition.

Another survivor said she was not listened to or believed when she re-presented to hospital with sepsis multiple times despite having previously had sepsis.

Another survivor talked about how her symptoms of post-sepsis syndrome were dismissed and put down to a pre-existing condition and her age.

The mother of a young sepsis survivor described the difficulty her daughter experienced throughout her sepsis journey. She said that medical professionals consistently attributed the signs of post-sepsis syndrome to her age and developmental stage, which meant she did not receive treatment for fatigue and psychological impacts of sepsis. This had a significant impact on her relationships with her peers and created worry and stress for her family members.

One parent bereaved by sepsis described how her concerns for her child were dismissed.

Another person bereaved by sepsis recalled asking a member of the treating team about several concerning symptoms she had observed in her husband. She was told that it had nothing to do with what they were treating for, and in another instance was laughed at for asking a question about something about his condition that alarmed her.

People who have lost loved ones to sepsis universally reported that their concerns hadn't been listened to or been understood by health care providers.

... As soon as I got to ED I was put into resus. I was on life support, but I wasn't high priority enough to have to receive an ambulance. I had to go to hospital by Uber. – Sepsis survivor, focus group

When I had this a third time, I recognised it early and I tried to get into my local ED, but they fobbed me off and I deteriorated the next day ... it's a horrible thing to remember. Now I [have] a letter signed by [an infectious disease specialist] with my history, that says please don't turn me away. – Sepsis survivor, focus group

Specialists didn't take me seriously when I was explaining how fragile I was ... they were all saying it's all down to rheumatoid arthritis ... Once you turn 65 it's all about your age. – Sepsis survivor, focus group

Listen to your patient, look at your patient. The vitals can help form the picture but actually engaging with your patient is far more important. My sister died asking for help which was never provided. – Person bereaved by sepsis, survey

Coordination and support can reduce the burden of self-advocacy on consumers.

Sepsis survivors reported having to repeatedly self-advocate to get their concerns and symptoms addressed. This process was often long, frustrating and stressful.

One survivor reported having to advocate to receive her discharge summary.

Sepsis survivors and people bereaved by sepsis described their frustration about the lack of understanding from people within the health care system of patient, family and carer experiences. These interactions compounded the challenge of recovery, or for those bereaved by sepsis, the grieving process.

Providing better coordination at transitions of care could lessen the burden of self-advocacy required to ensure information is received and needs are met. This will require:

- improving information about sepsis provided at handovers within hospitals
- improving the quality and completeness of discharge summaries, to ensure these include a sepsis diagnosis and a care plan
- ensuring contact is made with a patient's primary health provider/s to share patient care needs, rather than relying on the patient
- coordinating with the National Disability Insurance Scheme (NDIS) where relevant.

During my time at hospital, I had temporary heart and kidney failure. I realised that several months after discharge and I had to ask – practically beg – for a referral to a cardiologist to assess my heart health. However, I did get a referral to infectious diseases straight away. There was no question about that. But ... cardiology wasn't even a thought. I wish it was a process where I didn't have to advocate for myself so strongly. There's a lot of people who wouldn't have had the knowledge and understanding that I did at the time to be able to advocate for myself. - Sepsis survivor, focus group

... even though I'd been in hospital there for 10 weeks, I had to fight to get a letter of discharge and it took me 3 months to get [it]. I had to go through the CEO of the hospital ... they're all buck-passing. – Sepsis survivor, focus group

[A medical professional said to my husband] 'do not mollycoddle her at home, she needs to learn independence'... It brought me down to rock-bottom. – Sepsis survivor, focus group

They didn't listen to what we were saying during treatment and after my father's death our questions and concerns were fobbed off because we were in a state of shock and distraught and they were like, 'you aren't thinking straight'. – Person bereaved by sepsis, interview

Limited follow-up and care coordination is impacting recovery. Communication and collaboration across care transitions and long-term care planning is required.

US data identifies two common causes of hospital readmissions for sepsis survivors as medication errors and recurrence of primary infection or new infection.¹⁴ Setbacks to a survivor's recovery add further emotional and financial stress. Coordination and planning can give survivors and families important information and management strategies.

Adjusting to life with post-sepsis syndrome and/ or coping with sepsis related trauma and loss is more difficult when survivors, their families and carers have to identify, coordinate and manage health services and supports alone.

Navigating health services can be difficult and time consuming, requiring research skills and confidence to ask for support and referrals. Sepsis survivors and their families need factual information and open communication to build understanding about sepsis and post-sepsis syndrome and to normalise their sepsis experience. This is essential for recovery and wellbeing.

Key information needs identified in consultations with people with lived experience and health stakeholders were:

- awareness raising for the general public about sepsis
- listening to patients, families and carers in a non-judgemental way, and providing them with a timely second opinion if asked for
- communication with patients, families and carers about a sepsis diagnosis, and how serious it is
- communication about treatment and patient condition, being factual about potential outcomes

There's not a lot out there, aside from what I've chased after myself. I'd imagine hydrotherapy or physiotherapy would be great ... psychological support after an ICU admission would be great, I'd imagine. Occupational Therapy may be helpful, especially if needed to help make adjustments when living with ongoing fatigue, but I wouldn't know as I don't know where to go to get that sort of support. - Sepsis survivor, survey

I'm educated, have worked in the health sector and am good at dealing with admin/ bureaucracy, chasing doctors, educating myself on things and finding ways to work with systems that aren't the easiest to work with. I've been lucky and actively sought those things myself, and it's really hard to think what the outcomes would have been if I didn't have that privilege going in. – Sepsis survivor, focus group



- multimodal communication (verbal as well as written, infographics or audiovisual) about what sepsis is, its impacts, potential for recurrence, realistic timeframes for recovery, and what Post Sepsis Syndrome symptoms look like
- the use of translators and translated resources for patients, families and carers whose primary language is not English
- keeping key contacts informed (family members, partners, carers) where they are unable to be physically present with the patient
- information about available care and supports available after discharge and how to access them
- information on what to do to support recovery (e.g. nutrition)
- information about GPs and allied health providers experienced in working with sepsis survivors
- information about available bereavement support and how to access it.

The financial burden of sepsis can be significant. Survivors and the bereaved may need additional support as they adjust to life after sepsis.

There are a range of financial impacts on people with lived experience of sepsis. Many sepsis survivors are unable to return to work for a period of time or permanently, and other family members may also need to take time off work to provide care.

In one example, a sepsis survivor having used their financial reserves and their accrued sick, annual, and long-service leave, was only able to progress their Disability Support Pension application with the help of their Local Member. During that time, they were unable to access essential oxygen therapy because they could not afford to pay for it themselves.

A family member of a sepsis survivor told us her late husband had lost his business due to chronic pain and that they endured financial stress associated with increased cigarette and alcohol consumption, used to manage his mood and symptoms. His widow reported he had had an expensive surgery to treat symptoms they later discovered were related to post-sepsis syndrome and not a back injury.

People bereaved by sepsis also experience financial burden. The sudden loss of income and costs associated with burial and funeral service, legal advice, hospital expenses and personal health and wellbeing are difficult to manage. There are also specific economic impacts on families who have lost a child. Bereaved parents are more likely to leave employment, get divorced and experience future mental health issues.¹⁴ This has implications both for the parents and other surviving siblings and relatives. Families reported that health system

responses do not reflect the time and support required to adjust to and recover from a sepsis death.

The impacts of changed capabilities around work are not always financial. Some survivors

Some people need to leave a job in order to recover. – Sepsis survivor, focus group

Financial costs were pretty huge for us initially, living rural. I had a 5-month-old and a 3-year old. So, when I was discharged my husband had to give up work ... local people were cooking meals for us to help out a bit, and they would drop them off once a fortnight ... so, those sort of really informal supports would be [the] only help we had. – Sepsis survivor, focus group

I think social work have a responsibility to be more involved and trying to access what is available to people when they become unwell, even when they are working. – Sepsis survivor, focus group

My wages covered smokes and wine – that was his coping mechanism. He was depressed and in pain. That cost a lot. Every month when paying with credit card we struggled. – Family member of sepsis survivor, interview

Financially the impact was huge but not so much as a struggle [because] I am fortunate enough to own my home but I am a very independent person and paid my way my whole life but now I rely on my husband. [It's] extremely demoralising, losing [my] self-worth. – Sepsis survivor, focus group

also reported impacts on their sense of self-worth and independence as a result of their inability to work.

People bereaved by sepsis have long-term health needs. Timely information and support is required as they adjust to life after a sepsis.

People bereaved by sepsis need ongoing support as they process circumstances of losing someone to sepsis. Sepsis deaths are traumatic. Families reported:

- it was fast and chaotic
- uncertainty about how to best advocate for their loved one
- it was distressing and frightening to observe the rapid progression of sepsis and be powerless to do anything to help
- they were left with a sense of confusion about what had happened, especially when treating medical professionals were uncertain about the source of infection



- they did not feel well enough informed about the acuity of their loved one's illness and that death was a potential outcome, nor about the sepsis diagnosis and what sepsis was
- they experienced guilt and shame for their loved one's death; asking 'should I have acted faster to get help, advocated more strongly for rapid treatment, or known more about sepsis to identify the signs?'
- there was a lack of empathy from medical professionals at the time of their loss which made some feel a sense of being failed by the health system
- they had to do their own research to find information and supports, including googling sepsis and finding grief services and peer support groups
- the increased distress and trauma when required to speak to the police right after the death, often in public spaces and with limited consideration of their needs.

Traumatic loss is recognised as a trigger for post-traumatic stress disorder, major depressive disorder and persistent, distressing and disabling grief that is prolonged or persistent.¹⁵ This does not occur for all those who have experienced a traumatic loss, but can impact significantly on people's work, physical wellbeing and social functioning.¹⁶

"The bereavement period is associated with increased use of health services and worse morbidity and mortality and thus has significant implications for public health."¹⁷

"People with complicated grief are at increased risk for cardiac disease, cancer, hypertension, substance-use disorders and suicidality."¹⁸

Consultations with people who have been bereaved by sepsis stressed the importance of open disclosure, giving families and carers the opportunity to meet with relevant clinicians and hospital staff to help understand what happened, particularly when the onset of sepsis, deterioration and death has been very rapid.

Conversations with health stakeholders indicated that clinicians may also need personal support after a sepsis death, and education and guidance about how to speak with families about their loss in a compassionate and supportive way.

3. How will the model of care framework create more efficient and effective healthcare?

There is strong evidence that disease-specific coordinated care models lower the costs of providing healthcare and improve patient outcomes.¹⁹ Care coordination can help reduce risk and provide a more tailored care experience while improving patient satisfaction and outcomes.²⁰ It puts the needs of the consumer at the centre, supports navigation of the health system and facilitates collaboration, communication and information sharing between treating professionals.

Ongoing education for medical staff leads to improved recognition of sepsis and reduced time to treatment

Treatment of sepsis in an acute stage represents a high cost to the hospital system.²¹ It follows that earlier recognition and treatment of sepsis has the potential to create enormous cost-savings to the hospital system, as well as reducing impacts on sepsis patients' quality of life, and preventable deaths.

There is emerging evidence to support the link between a specific sepsis role and improved sepsis knowledge, recognition and treatment of sepsis. The implementation of the Queensland Paediatric Sepsis Pathway provides evidence about factors influencing knowledge translation and implementation of quality improvements. In addition to years of paediatric experience, the main predictor for improved knowledge between the 14 hospital sites in the study was dedicated funding for a specific role (sepsis quality improvement nurse).²² Anecdotally, after a sepsis coordination team commenced in Perth Children's Hospital, key performance indicators including 'time to antibiotics' improved.

Ongoing sepsis education for medical staff is required to support earlier recognition and treatment of sepsis. This is particularly important due to the high turnover of medical staff.²³

More accurate coding of sepsis patients enables more accurate Activity-Based Funding (ABF) payments

The National Efficient Price (NEP) and National Weighted Activity Unit (NWAU) inform the national ABF for public hospital services. Coding patients incorrectly is a risk for loss of ABF. Improved health workforce education about, and accuracy and compliance with sepsis documentation could increase the amount of ABF hospitals are eligible to receive. Health stakeholders reported a lack of alerts or flags about a sepsis diagnosis in many patient records systems. Identification of improvements that can be made to information



management systems that support the care a person with sepsis requires, may also support more accurate coding.

Reduction in avoidable readmissions reduces loss of ABF per treatment episode, 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. For about 20% of cases in the same study, readmission within a year of their first sepsis hospitalisation was for sepsis recurrence.²⁴

Readmissions in the first 30 days after discharge tend to be higher for people who have been transferred from another hospital, younger patients, those of greater socioeconomic disadvantage and those who reside outside a major city.²⁵

Consultations with sepsis survivors also identified several factors that could reduce re-hospitalisations including providing:

- sepsis survivors, families and carers with more information about medication management, sepsis and post-sepsis syndrome
- more timely and informative discharge summaries including a diagnosis of sepsis, information on sepsis and a post sepsis care plan
- sepsis informed care by medical professionals within hospital and in primary care. This care should be more attentive and attuned to the needs and concerns of patients, their families and carers.

International evidence indicates that investment in the coordination of care and post-sepsis support can reduce unnecessary readmissions. A randomised clinical trial of a 30-day Sepsis Transition and Recovery Program (STAR) noted, "post-sepsis rehospitalisation costs a total of \$3.5 billion annually in the United States. Extrapolating the nearly 8% observed absolute reduction in rehospitalization could result in \$300 million in cost savings per year."²⁶

Avoidable readmissions have repercussions for hospital funding. 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.²⁷ This means that hospitals are bearing more of the financial risk of avoidable readmissions (Table 1). A reduction in avoidable rehospitalisations due to unresolved infections or new infection could 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.



Table 1 Risk adjustment factors for avoidable hospital readmission for infection

Risk factor	Adjustment
Low complexity case	Funding for the index admission NWAU is reduced by 100% of the readmission NWAU
Moderate complexity case	Funding for the index admission NWAU is reduced by 55.6% of the readmission NWAU
High complexity case	Funding for the index admission NWAU is reduced by 45.5% of the readmission NWAU

Source: IHACPA (Independent Health and Aged Care Pricing Authority) (2025) [National Efficient Price Determination 2025–26](#), IHACPA. Pg. 102

Better transitions from hospital to home will better enable people to heal and reduce ineffective use of health services

Health stakeholder and consumer consultations identified a range of issues that could be better addressed during discharge planning to facilitate recovery. Beyond the need to improve the health and quality of life outcomes for sepsis survivors, families and carers, there is also strong economic rationale for improving transitions between the hospital and home.

- Promoting greater utilisation of community-based health providers can support compliance with post-discharge care advice and medication, reducing readmissions and reliance on hospital services.
- Improving discharge summaries by documenting sepsis and providing care plans that are focussed on the holistic needs of the sepsis survivor, their families or carer may help to reduce ineffective use of GP and specialist visits. This will improve outcomes for patients and reduce government expenditure on inefficient use of primary carers time.
- A NSW Government study estimated that 'no-shows' to outpatient appointments cost between \$125 and \$800 per appointment.²⁸ Increasing the use of outpatient services for follow up assessments may help prevent complications, reduce avoidable readmissions, and improve post-discharge compliance. Coordinated care to support patients to overcome attendance barriers leading to higher attendance rates at these appointments.

Addressing the support needs of people bereaved by sepsis may reduce the health impacts of trauma

Trauma and complex grief can increase a persons' risk of cardiac disease, cancer, hypertension, substance-use disorders and suicidality.²⁹ People diagnosed with PTSD have reportedly higher healthcare costs and increased recovery times.³⁰

People bereaved by sepsis told us that what's most useful in supporting their healing is:

- better connection with peer support groups
- opportunities to request information and understand what has happened
- follow up from the institution that treated their loved one
- financial support, especially to access mental health services.

3.1 Avoidable costs case stories

While there are costs to the acute health system due to the lack of coordination of care and post-sepsis support, there are also costs to the patient and broader government support systems. Fictionalised case stories based on common themes from the experiences of sepsis survivors have been developed to show these broader costs. These highlight how investment in coordination and post-sepsis care by health services can contribute to improving the patient experience and their long-term health, wellbeing and financial outcomes.



Figure 1 Avoidable cost case story: Miriam and Carla

Miriam and Carla

Miriam takes her 12-year-old daughter Carla to ED with a fever and vomiting. Miriam is concerned that Carla has a UTI that has spread to her kidneys. As they wait to be seen, Carla's condition deteriorates. She is admitted to the specialised children's hospital, where she becomes increasingly unwell. The treatment team suspect sepsis and put her on the sepsis pathway.

Issues causing avoidable costs are highlighted in red

Coordination of care

Doctors explain Carla has a very bad infection. After two weeks in hospital, Carla begins to recover, and they take her home. **Discharge summary only notes infection, not sepsis.**

Post-sepsis

Carla continues to experience a lot of fatigue, pain and confusion, often doesn't want to get out of bed and has to be picked up from school early many days. She has become very anxious and down, and her friendships are affected. Her teachers say she is disengaged in class, and often has her head on her desk.

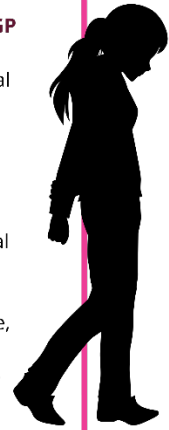
They visit the GP, who puts Carla on anti-depressants. **Govt cost: \$40 Family cost: \$40**

Anti-depressants don't seem to help. **Miriam often has to take unpaid leave to stay home with Carla. Family cost: \$4794** (3 weeks lost earnings)

Miriam researches online to try and understand what is happening. Eventually she finds information on sepsis and post-sepsis syndrome (PSS), which seems to explain Carla's symptoms. She brings this up with the GP at their next appointment but the **GP is unaware of post-sepsis syndrome**, and is more interested in Carla's mental health.

Govt cost: \$40 Family cost: \$40

Carla becomes very unwell again several months after hospitalisation, and they take her to ED. Miriam tells them she thinks her daughter had sepsis last time, and gets confirmation that this is in her patient record. Miriam is angry that she wasn't told. It would have helped her communicate with the GP, and get treatment for Carla's PSS. Carla is treated for sepsis recurrence. Miriam advocates for the sepsis history to be put in the discharge summary, and for a care plan she can take to discuss with the GP.



Miriam's boss is frustrated by Miriam's absences. She is encouraged to **drop to 0.5FTE** so the business can hire another staff member.

Family cost: \$41,548 (lost earnings from loss of 0.5FTE income over 12 months)

Carla is doing better once she is seeing a psychologist, a physiotherapist and an occupational therapist, however she is still **held back a year at school**.

This affects her friendships, and her self-belief, and as a result she needs **more frequent psychology appointments.**

Govt cost: \$26,495 Family cost: \$4500

ESTIMATED AVOIDABLE COSTS OVER 12 MONTHS
Government: \$26,575
Family: \$50,922

Sources for cost estimates are provided in Appendix 1. Alt text long description is provided in Appendix 2.



Avoidable cost case story: Barry

Barry

Barry is a 62 year old man working full time. He's had an achy tooth for a while, and then starts to feel quite unwell at work.

Issues causing avoidable costs are highlighted in red

Coordination of care

GP diagnoses as **gastro** and sends Barry home to rest
Govt cost: \$40 Patient cost: \$40

Presents to Emergency, is triaged, diagnosed with a dental abscess and sepsis and treated with antibiotics. Transferred to a ward and stays for 3 days. **Discharge summary lacks a diagnosis of sepsis.**

At home, Barry is foggy and doesn't understand what made him so sick, or why it's important to take his antibiotics. He forgets to take them.

Taken by **ambulance** to hospital 2 days later after a fall that renders him unconscious and **injures his shoulder**. Treated for sepsis recurrence with antibiotics, short stay on ward, seen by in-hospital physio for shoulder injury.

No discharge summary provided, it's sent to GP a week later
Govt cost: \$23,346

Post-sepsis

Attends GP within 3 days of as instructed. **GP doesn't have discharge summary**. Barry is unclear on the purpose of follow up. They focus on the shoulder injury. Referral provided to physiotherapist.

Govt cost: \$40 Patient cost: \$40

Barry attends the physio. He's very tired and is having a lot of joint pain, but doesn't know about post-sepsis syndrome, so they focus on the shoulder injury. The physio repeats the information Barry was given by the physiotherapist in hospital, but it doesn't do anything for the joint pain.

Patient cost: \$112

Barry has to take **time off work** with fatigue and joint pain. Some days he pushes through. This makes him feel more exhausted and unwell. He is contemplating dropping his work hours, though he needs the money. He **sees the GP again**, who provides a referral to an osteopath.

Govt cost: \$40 Patient cost: \$728 (lost wages and GP)

The **osteopath** reviews Barry's history and suggests seeing a neurologist. Barry returns to the **GP to get a referral**.

Govt cost: \$40 Patient cost: \$216

The neurologist is attached to the hospital where Barry was treated, and has visibility of Barry's patient records. They also have experience of working with patients who have had sepsis.

The neurologist provides treatment that supports Barry to manage his pain, and provides a letter Barry can take to his employer to discuss work adjustments. These adjustments allow Barry to **continue working full time for another 12 months**

Saving to patient: \$93,028 in earnings



ESTIMATED AVOIDABLE COSTS OVER 12 MONTHS

Government: \$23,506

Patient: \$1,136

Sources for cost estimates are provided in Appendix 3. Alt text long description is provided in Appendix 4.



4. Resourcing Ideas

4.1 What coordination of care and post-sepsis support could look like

Coordination of care for patients while they are admitted in hospitals and support post-sepsis could be delivered as a cohesive program, or as separate but collaborating roles embedded within different parts of the health system. Some ideas are provided below based on examples from existing integrated models and on reports from health stakeholders and consumers about what is needed.

4.1.1 In-hospital coordination of care

What could this look like?

Sepsis coordination roles could be held by a Clinical Nurse Consultant, Nurse Practitioner or Social Worker, supported by a clinical lead. Roles could be implemented at department, hospital, network level, or district-wide (as appropriate to patient load). Sepsis champions on wards and in departments, supported by a centralised sepsis coordinator may be another way to embed in-hospital sepsis care coordination.

Sepsis coordination activities might include:

- building relationships with patients, families and carers
- participating in daily rounds and case reviews
- providing information and education for consumers throughout the journey
- leading and coordinating education for health teams within hospitals, and for GPs and other community care providers
- supporting collaboration between and across treating teams
- ensuring clinical documentation contain the word sepsis to support coding
- ensuring discharge summaries contain sepsis diagnosis information on post-sepsis syndrome
- work with treating professionals, patients, families and carers to assess holistic needs, identify recovery goals, and provide a care plan prior to discharge
- coordinating referrals to outpatient services, home care services and other supports. This may include planning for a post-discharge follow up call.
- leading quality improvement activities, including documentation and coding checks, and morbidity and mortality reviews



- providing information packs that can be given by clinicians to consumers
- coordinating access to home aids or adjustments needed to return home
- supporting people bereaved by sepsis through open disclosure processes.



4.1.2 Post-sepsis support and care coordination

What could this look like?

Post-sepsis coordination and support activities could be implemented at a hospital, network, district or state/ territory level (appropriate to patient load), perhaps also in collaboration with primary care providers. As a nominated contact for sepsis survivors, families, carers and people bereaved by sepsis, this role could focus on coordinated transitions including from hospital to home. There is an opportunity for co-design/co-commissioning between acute and primary care health services to develop a holistic approach.

Outpatient services could also be leveraged to bridge hospital to home transition, providing coordination support for follow-up health assessments and GP liaison. This could be especially useful for survivors with complex and chronic health needs, people living regionally or remotely, and or those from other priority cohorts.

Post-sepsis coordination activities might include:

- providing follow up assessment of survivors' condition, including medicines safety (with pharmacist), concerns about post-sepsis syndrome and care escalation as needed
- liaising with primary care teams to facilitate a successful care transition and support post-sepsis planning
- periodic monitoring and review, including readmissions, infection/sepsis recurrence, pain management, rehabilitation progress, mental and physical wellbeing, financial needs, and current/ future referral needs
- informing and facilitating connection to peer support
- responding to consumer and health professional enquiries about sepsis and post-sepsis syndrome
- supporting communication between treating professionals
- supporting referrals to mental health services, family and/or child counselling
- providing information and resources about sepsis and post-sepsis syndrome to help survivors and families explain the impact of sepsis to their employer, school etc
- coordinating multiple appointments
- contacting people bereaved by sepsis periodically to offer information and identify potential supports for individuals and if needed, for the family.

An essential component of all sepsis coordination is driving multidisciplinary and interagency collaboration, including between emergency, acute and outpatient medical teams and specialists, social workers, translators, Aboriginal liaison officers, pastoral care teams,



discharge planners, primary care clinicians, other government agencies (for example National Disability Insurance Scheme) and community, disability and aged care providers.

4.2 What kind of funding and resourcing options are there?

Options for resourcing coordination of care and post-sepsis support include:

- making sepsis coordination part of an existing role or resourcing a new role (which has the potential to increase the amount of ABF a hospital is eligible for, by improving sepsis coding, and reducing avoidable readmissions)
- making sepsis follow-up care part of an existing role, an outpatient service, or resourcing a new role (which also has the potential to generate ABF)
- co-commissioning a role between entities (for example: Primary Health Networks, Local Health Districts, hospital and health services, nonprofit health providers, ACCHOs, private hospitals, residential aged care facilities)
- commissioning a role within a nonprofit service provider
- educating and providing guidance and resources to existing nurse navigators, and disease-specific coordinators who are likely to work with patients with a higher risk of sepsis (such as cancer, diabetes care, cardiac, stroke, Aboriginal and rehabilitation care coordinators)
- funding role/s at a state health department level (for example a Clinical Excellence Commission or equivalent).

4.2.1 Build on existing systems, models and tools

Implementation of the model of care framework should consider how existing care pathways, models of care and support services can be leveraged. Consumer and healthcare stakeholders agreed that integration with existing sepsis clinical pathways would be the most effective and efficient way to increase services and supports, although each group acknowledged that some new investment would be required.

Analysis identified several synergies for sepsis coordination and post-sepsis support within existing systems. Discharge planners, nurse navigators, complex care nurses, patient flow coordinators, social workers, outpatient clinics and community care programs (such as Hospital in the Home programs) are already in place in several settings. Undertaking a review of these services and programs to assess whether and how sepsis survivors, families, carers and people bereaved by sepsis can be connected in would support more efficient and effective health system usage and lead to better outcomes.



Many hospitals and health services also have existing bereavement support resources and programs. People bereaved by sepsis should be routinely supported to access these supports.

Existing tools released by the Commission to support the implementation of the Sepsis Clinical Care Standard can be better used to support coordination of care and post-sepsis support:

- [Self-Assessment Tool – Sepsis Clinical Care Standard](#)
- [Sepsis coordination roles and responsibilities](#)
- [Discharge planning guide for patients with sepsis](#)
- [GP letter template for discharge](#)
- Information for people with sepsis and their families
 - [For adults](#)
 - [For children](#)
- [Bereavement support after sepsis brochure](#)
- [Post Sepsis Syndrome Screening Tool](#)



5. Case studies: similar programs

5.1 Case study: Think Sepsis Scaling Collaboration

The 'Think Sepsis. Act Fast' Scaling Collaboration was established by Safer Care Victoria in partnership with Melbourne Health and 11 health services.³¹ Over 12-months it aimed to implement a nurse-led whole of hospital sepsis pathway that reduced variation in management of patients with sepsis, improved clinical outcomes, and increased consumer engagement in sepsis management through:

- implementing an adult sepsis clinical pathway previously piloted by Melbourne Health (enabling some local adaptation)
- delivering a multidisciplinary education package
- ensuring lessons and resources from implementation were captured and shared between health services through a digital portal
- engaging consumers in the management of sepsis (e.g. through representation on steering committees, design and review of consumer information brochures, educational videos and at promotional events).³²

The project established a clinical lead (0.2 FTE), a project lead (1.0 FTE), and a database manager (0.2 FTE) within Melbourne Health, the champion organisation. These roles were responsible for overseeing and facilitating the project and change management processes.³³ Each of the 11 collaborating health services recruited a project officer (0.8 FTE) and a clinical lead position (0.1 FTE).

There were significant patient and process outcomes from the delivery of this model, including:

- 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
- saved \$11.7 million based on reduced LOS and reduction in cost over three to four months
- demonstrated a six-fold return on the amount invested
- demonstrated a 73.1% improvement³³ in adherence to the sepsis pathway.



The economic benefits were also significant. The 'Think Sepsis. Act Fast' Scaling Collaboration received \$1.8 million in funding from the Better Care Victoria Innovation Fund, and returned \$11.7 million in savings from reduced length of stay and reductions in the cost of ICU (reduced cost of \$3195 per ICU admission).³⁴

Other benefits documented in the evaluation of the program included:

- improved sepsis awareness across all health services
- empowerment of clinical staff to escalate cases
- improved communication between clinicians and consumers
- upskilling of nurses in key skillsets relating to sepsis management
- 82% of those in project management roles reported improved project skills, supporting them to effectively deliver similar projects in future.

The evaluation emphasised how central the funded project roles both within Melbourne Health and within each health service were to successful roll-out of the project, as well as the importance of having a clinical lead to support clinician buy-in and implementation.

5.2 Sepsis Transition and Recovery Program (STAR)

The Sepsis Transition and Recovery Program (STAR) model in the United States targets patients who are considered at high risk of readmission.²¹ STAR is delivered by sepsis recovery navigators who facilitate care through telehealth evaluations and modifications of the patient care plans. Adults hospitalised for suspected sepsis and deemed at high risk for 30-day rehospitalisation and mortality are eligible for the program.

The STAR navigator engages with the patient prior to discharge to build trust to support meaningful engagement post discharge. The navigator is involved in:

- optimisation of medicines. This includes engaging with pharmacists to explore the need for medications management and liaising with patients to ensure they have the right medications and know how to take them and monitor for side-effects
- coordination of allied health to screen for functional, cognitive and mental health problems during hospitalisation
- assessments of functional limitations and cognitive and mental health problems post discharge using phone adapted tools. Protocols are provided to guide responses including possible referrals or help secure home supports or equipment
- monitoring symptoms, screening for infection symptoms and comorbidities at each contact
- optimisation of care goals. This includes facilitating palliative care consultation during hospitalisation where needed and understanding, documenting and communicating discharge goals for future care and liaison with primary care physicians.²⁵

A randomised clinical trial showed STAR achieved a 7.5% reduction in rehospitalisation over a 12-month period.²¹ It was effective in addressing two of the most common reasons for readmission: medication errors and incomplete resolution of infection or a new infection.¹⁰ It was noted that the model has some limitations. For example, virtual delivery is less effective in reaching patients with unstable housing and telephone access.

5.3 Case Study: Queensland Paediatric Sepsis Program

Children's Health Queensland (CHQ) is delivering the Queensland Paediatric Sepsis Program, which has delivered:

- a co-designed and evidence-based Paediatric Sepsis Pathway for screening and recognition, and a sepsis in children website for health workers (implemented 2018)²⁶
- resources (embedded in the Pathway) for parents, carers and families of children with sepsis (in 12 languages), as well as for Aboriginal and Torres Strait Islander families
- information for parents of children who have died from sepsis
- a Paediatric Post-Sepsis Model of Care, based on consultation with health professionals and families and carers of children with sepsis, as well as people bereaved by sepsis
- a Family Support Program – an evolving model of care that aims to provide education about sepsis and post-sepsis supports through online videos, website, webinars and public awareness campaigns; offer psychological support and create peer connections.^{27,28}

A dedicated Paediatric Sepsis Clinical Nurse Consultant (CNC) provides education to clinicians and supports patients and families during and after a sepsis diagnosis.²⁹ This role was the first Paediatric Sepsis CNC in Australia.

The Queensland Paediatric Sepsis Program has a 5-year roadmap, with goals including:

- standardised practice
- earlier back transfer to local hospital (where required)
- reduction in hospital and PICU length of stay
- increase appropriate use of antimicrobials
- sustainable integration into education curricula
- increased empowerment and support of families
- clinician and families have increased knowledge of sepsis and confidence in recognising signs.²⁶

It aims to deliver on these by focusing on 6 areas:

- dedicated team

- systems level
- coordinated care
- communication awareness and knowledge
- clinical education training and resources
- data and digital.²⁶

5.4 Case Study: Perth Children's Hospital Sepsis Program

We interviewed a full-time Sepsis CNC at Perth Children's Hospital, a tertiary paediatric facility. The hospital's Sepsis Program, established in 2022, also includes a 0.2 FTE clinical lead (medical) and 0.4 FTE administrative support. The Sepsis CNC emphasised that having dedicated clinical leads was essential for the successful implementation of the hospital's sepsis pathway and education initiatives.

The Sepsis CNC's responsibilities include:

- developing and monitoring the paediatric and neonatal sepsis pathways, along with the Paediatric Sepsis Clinical Practice Guideline³⁰
- auditing performance against the Sepsis Clinical Care Standard and reporting results through newsletters and an annual report to the Standard 8 Committee
- delivering mandatory sepsis pathway education to clinicians, as well as additional educational sessions within the hospital and across the state
- promoting sepsis awareness through events such as World Sepsis Day and Paediatric Sepsis Week
- leading community outreach and education activities, including engagement with community hubs to improve access for culturally and linguistically diverse, and Aboriginal and Torres Strait Islander families
- developing and implementing a post-sepsis follow-up program.

After 1 year of funding these dedicated roles, the health service reported measurable improvements in the timeliness of antibiotic administration. The median time from recognition to antibiotic administration decreased from 60 to 45 minutes. The proportion of children receiving antibiotic therapy within recommended timeframes significantly increased (for both those with septic shock within 60 minutes 70.0% to 93%; and without shock within 180 min; 86% to 95%).³⁰

In the second year, the team developed a neonatal sepsis pathway, rolled out the paediatric sepsis pathway statewide, and launched a follow-up program, which is now generating activity-based funding for the program.



5.5 Case study: RuralkidsGPS

RuralkidsGPS, an integrated paediatric care coordination model of care in rural Australia, established a new 0.5FTE care coordinator within 3 local health districts (Lingam et al., 2024). Their role is to facilitate care integration for children and young people with medical complexity via a 'circle of coordination formed by the leads from the health service, community and family'.³¹ The program incorporates an assessment of family, clinical and system support needs, coordination, monitoring and evaluation of clinical outcomes, goals and unmet needs.

The evaluation of RuralkidsGPS showed that it delivered:

- 40% fewer emergency department presentations
- 42% fewer day-only admissions
- approximately \$2.5 million/annum in savings for the tertiary hospital network
- 50,000 km of family travel avoided.³¹



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Appendix 1. Miriam and Carla - avoided costs case story data

Type of cost	Govt Cost	Patient Cost	Source	Justification
GP visit	\$40	\$40	Medical Costs Finder	Based on standard GP consult.
Lost productivity (unpaid leave x 3 weeks)		\$4,794	ABS (2024) Employee Earnings , Australian Government.	ABS 2024 median weekly earnings for full-time female employees \$1,598.
Loss of income (0.5FTE) x 1 year		\$41,548	ABS (2024) Employee Earnings , Australian Government.	ABS 2024 median weekly earnings for full-time female employees calculated at a loss of 0.5FTE over 1 years.
Psychologist (10 sessions)	\$4650	\$4500	Basford Canales, S (8 February 2024) Subsidised psychologist sessions plummet amid calls on Labor to reinstate extra Medicare Visits , The Guardian.	Based on the minimum 10 sessions per year at \$90 out of pocket and \$93 Medicare rebate x 5 years remaining in school.
Repeats a grade at school	\$26,495		NSW Treasury (2025) Outcome Values Database , NSW Government	Based on Treasury NSW Outcomes Values Database value for avoided grade repetition in secondary school.

Appendix 2. Accessible description of avoided costs case story: Miriam and Carla

- 35.** Miriam takes her 12-year old daughter Carla to ED with a fever and vomiting. Miriam is concerned that Carla has a UTI that has spread to her kidneys. As they wait to be seen, Carla's condition deteriorates. She is admitted to the specialised children's hospital, where she becomes increasingly unwell. The treatment team suspect sepsis and put her on the sepsis pathway.
- 36.** Doctors explain Carla has a very bad infection. After two weeks in hospital, Carla begins to recover, and they take her home. Discharge summary only notes infection, not sepsis.
- 37.** Carla continues to experience a lot of fatigue, pain and confusion, often doesn't want to get out of bed and has to be picked up from school early many days. She has become very anxious and down, and her friendships are affected. Her teachers say she is disengaged in class, and often has her head on her desk.
- 38.** They visit the GP, who puts Carla on anti-depressants. Government cost: \$40 Family cost: \$40.
- 39.** Anti-depressants don't seem to help. Miriam often has to take unpaid leave to stay home with Carla. Family cost: \$4,794 (3 weeks lost earnings).
- 40.** Miriam researches online to try and understand what is happening. Eventually she finds information on sepsis and post-sepsis syndrome (PSS), which seems to explain Carla's symptoms. She brings this up with the GP at their next appointment but the GP is unaware of post-sepsis syndrome, and is more interested in Carla's mental health. Government cost: \$40 Family cost: \$40.
- 41.** Carla becomes very unwell again several months after hospitalisation, and they take her to ED. Miriam tells them she thinks her daughter had sepsis last time, and gets confirmation that this is in her patient record. Miriam is angry that she wasn't told. It would have helped her communicate with the GP, and get treatment for Carla's PSS. Carla is treated for sepsis recurrence. Miriam advocates for the sepsis history to be put in the discharge summary, and for a care plan she can take to discuss with the GP.
- 42.** Miriam's boss is frustrated by Miriam's absences. She is encouraged to drop to 0.5FTE so the business can hire another staff member. Family cost: \$41,548 (lost earnings from loss of 0.5FTE income over 1 year).
- 43.** Carla is doing better once she is seeing a psychologist, a physiotherapist and an occupational therapist, however she is still held back a year at school. This affects her friendships, and her self-belief, and as a result she needs more frequent psychology appointments. Government cost: \$26,495 Family cost: \$9,191.
- 44.** Estimated avoidable costs: Government: \$26,575; Family: \$234,411.



Appendix 3. Barry - avoided costs case story data

Type of cost	Govt Cost	Patient Cost	Source	Justification
GP visit	\$40	\$40	Medical Costs Finder	Based on standard GP consult
Ambulance call out	\$915		Compare the Market (2025) ' Australian Ambulance fees are some of the highest in the world, new report finds '. Compare the Market.	Average cost of ambulance call out fees across Australian States and Territories
Avoidable readmission	\$22,431		ACSQHC 2024, Epidemiology Report, Table 8	\$17,954 per readmission, plus 25% (to account for 25% increase in NWAU between 22/23 and 25/26)
Physio for shoulder injury		\$112	Comcare (2025) Rates for medical and allied health treatment , Australian Government	Average of the states' physiotherapy rates for initial consult and treatment.
Lost productivity		\$688	Deloitte (2019) The cost of pain in Australia Deloitte Australia .	"Absenteeism associated with chronic pain was estimated to cost \$3.2 billion in 2018, or

Type of cost	Govt Cost	Patient Cost	Source	Justification
				\$1,433 per working age Australian living with chronic pain". 48% is borne by the individual.
Osteopath visit		\$176	Comcare (2025) Rates for medical and allied health treatment, Australian Government	Recommended maximum rate for initial consult/treatment
Continued income for 1 year		\$93,028	ABS (2024) Employee Earnings , Australian Government.	ABS 2024 median weekly earnings for full-time male employees for 1 years.



Appendix 4. Accessible description of avoided costs case story: Barry

Barry is a 62 year old man working full time. He's had an achy tooth for a while, and then starts to feel quite unwell at work.

1. GP diagnoses as gastro and sends Barry home to rest. Government cost: \$40 Patient cost: \$40
2. Presents to Emergency, is triaged, diagnosed with a dental abscess and sepsis and treated with antibiotics. Transferred to a ward and stays for 3 days. Discharge summary lacks a diagnosis of sepsis. At home, Barry is foggy and doesn't understand what made him so sick, or why it's important to take his antibiotics. He forgets to take them.
3. Taken by ambulance to hospital 2 days later after a fall that renders him unconscious and injures his shoulder. Treated for sepsis recurrence with antibiotics, short stay on ward, seen by in-hospital physio for shoulder injury. No discharge summary provided, it's sent to GP a week later. Government cost: \$23,346
4. Attends GP within 3 days of as instructed. GP doesn't have discharge summary. Barry is unclear on the purpose of follow up. They focus on the shoulder injury. Referral provided to physiotherapist. Government cost: \$40 Patient cost: \$40
5. Barry attends the physio. He's very tired and is having a lot of joint pain, but doesn't know about post-sepsis syndrome, so they focus on the shoulder injury. The physio repeats the information Barry was given by the physiotherapist in hospital, but it doesn't do anything for the joint pain. Patient cost: \$112
6. Barry has to take time off work with fatigue and joint pain. Some days he pushes through. This makes him feel more exhausted and unwell. He is contemplating dropping his work hours, though he needs the money. He sees the GP again, who provides a referral to an osteopath. Government cost: \$40 Patient cost: \$728 (lost wages and GP)
7. The osteopath reviews Barry's history and suggests seeing a neurologist. Barry returns to the GP to get a referral. Government cost: \$40 Patient cost: \$216
8. The neurologist is attached to the hospital where Barry was treated, and has visibility of Barry's patient records. They also have experience of working with patients who have had sepsis. The neurologist provides treatment that supports Barry to manage his pain, and provides a letter Barry can take to his employer to discuss work adjustments. These adjustments allow Barry to continue working full time for another year. Saving to patient: \$93,028 in earnings.
9. Estimated avoidable costs: Government: \$23,506; Patient: \$1,136



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