Today’s Hosts and Speaker

Moderator
- Steve Findlay, MPH, Senior Health Policy Analyst, Consumers Union, NPP Partner, and former Co-Chair of the NPP Safety Workgroup

Featured Speaker
- Peter Pronovost, MD, PhD, Medical Director, Johns Hopkins University School of Medicine

Today’s Reactor Panel

- Helen Macfie, PharmD, FABC, Senior Vice President, Performance Improvement, Memorial Medical Care Centers
- Michael Klompas, MD, MPH, Associate Hospital Epidemiologist, Brigham and Women’s Hospital
- Victoria Nahum, Executive Director, Safe Care Campaign
Welcome to the Patient Safety Webinar Series

The objectives of the series are to:

- Share strategies for “getting started” to accelerate improvements in national patient safety efforts
- Highlight the role of public-private partnership in achieving Partnership for Patients goals
- Describe NPP’s role in catalyzing action and enabling change

Objectives for Today’s Webinar

- Provide an opportunity for thought leaders in the field of hospital-acquired infections to share best practices, success stories, and strategies for getting started
- Generate action in organizations and communities nationwide

Objectives for Today’s Webinar (cont.)

- Provide examples of public-private partnerships working collaboratively to achieve results
- Address the Partnership for Patients goals of reducing catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infections (CLABSI), and ventilator-associated pneumonia (VAP)
About the Audience

- Quality Improvement Organization: 9%
- Supplier Industry: 1%
- University / Academy: 1%
- Healthcare purchaser: 12%
- Consumer organization: 12%
- Clinician (non-hospital): 12%
- Healthcare provider (non-hospital): 6%

Hospital: 21%
Other: 56%

Audience Regional Location

- South: 34%
- Midwest: 21%
- West: 17%
- Northeast: 16%
- No Response: 12%

Polling Question

Which demographic best describes your organization or community?
Developing a National Quality Strategy

Health reform legislation, the Affordable Care Act (ACA), requires the Secretary of Health and Human Services to “establish a national strategy to improve the delivery of healthcare services, patient health outcomes, and population health.”

HR 3590 §3011, amending the Public Health Service Act (PHS A) by adding §399HH(a)(1)

HHS' Domains and Principles for the National Quality Strategy

Principles reflect:
- Patient-centeredness and family engagement
- Quality care for patients of all ages, populations, service locations, and sources of coverage
- Elimination of disparities
- Alignment of public and private sectors

HHS 2011 National Quality Strategy:
Six National Priorities
1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family are engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.
NPP’s Ongoing Role in Consultation to HHS on the National Quality Strategy

NPP has been specifically asked to provide input to HHS on identified priorities as well as at least:

- three goals per priority area
- two strategic opportunities per goal
- two measures per goal

Partnership for Patients Goals

- **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010.

- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be **reduced by 20%** compared to 2010.

Partnership for Patients Nine Areas of Focus

- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Injuries from Falls and Immobility
- Adverse Drug Events
- Obstetrical Adverse Events
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism
- Ventilator-Associated Pneumonia (VAP)
Partnership for Patients: Goals for Hospital-Acquired Infections

- Catheter-Associated Urinary Tract Infections
  Goal: Reduce the number of CAUTIs by 50% by 2013.

- Central-Line Associated Blood Infections Goal:
  Reduce preventable CLABSIs by 50% by 2013.

- Ventilator-Associated Pneumonia Goal:
  Reduce preventable cases of VAP by 50% by 2013.

How Will Change Actually Happen?

And how will it happen at scale?

- There is no “silver bullet,” but we know we must:
  - work together
  - provide thoughtful incentives
  - engage patients and families, authentically
  - engage leadership
  - assist in the painstaking work of improvement
The Centers for Disease Control and Prevention (CDC) supports states in preventing hospital acquired infections (HAI) through funding and technical support:

- CDC has multiple investments with the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA)
  - $39.8 million in ARRA funds to 49 states, the District of Columbia, and Puerto Rico
  - $11.75 million in ACA funds for FY 2011; $20 million proposed for FY 2012
- Funds support state and local HAI prevention and control strategies, and improve the quality and quantity of HAI reporting

CDC contributes to HAI surveillance through:

- Maintaining the nation’s reference laboratory
- Developing new methods for susceptibility testing and environmental testing
- Providing direct support to hospitals, healthcare facilities and health departments when outbreaks occur

CDC Links and Resources

- State Prevention Projects Map
- National Healthcare Safety Network
- Healthcare Infection Control Practices Advisory Committee (HICPAC) Guidelines for CLABSI and CAUTI
- CDC’s Prevention Epicenters

These links are available in the Resources tab, on the top left corner of your screen.
Eliminating CLABSI: a model for reducing preventable harm

Peter Pronovost, MD, PhD, FCCM
Johns Hopkins University
Impact of Statewide Quality Improvement Initiative on Hospital Mortality

Impact of Michigan Keystone Project on Hospital Mortality
Getting to 0 in a Hospital

- CEO commits to 0
- ICU leaders accountable, know rates, commit to 0
- ICU makes it easy to comply with checklist
- ICU empowers nurses to ensure compliance
- ICU reviews every infection as a defect
- ICU standardizes, audits, and improves catheter maintenance
- ICU posts and discusses infection rates weekly without an infection

http://www.modernhealthcare.com/article/20110725/SUPPLEMENT/307259972/-1

How Can We Spread

- A fractal is the same geometric pattern repeated in different sizes and shapes.
- Each piece is part of the whole.
- Provides mechanism for vertical and horizontal integration
Levers to Support Change

- Regulatory
- Hierarchy - management
- Economic pressure
- External Social pressures
- Networks/ Communities provided with technical support

Clinical Communities

- Commit to work together to achieve goals
- Responsible for outcomes
- Interdependent and united by common purpose
- Supported by vertically integrated technical core
- Supports horizontal learning
- Supports participatory forms of decision making
- Adaptable and flexible
- Aveling, E. 2011

Why Did This Work

- Started with goal and worked backwards
- Kept score with measure clinicians believed valid
- Guided by science, phase 1, 2, 3
- Committed to collaborate
- Modified locally to fit context
- Focused on adaptive work
- Framed CLABSI as a social program capable of being solved
- Created a community

Laws and the enforcement of laws, important though they are, can never substitute for the character of the citizens themselves

Teddy Roosevelt
References


Response from the Audience

Tell us about your experience in reducing infections in the ICU

What supports do you need to accelerate change and improve patient safety in your organization?

To provide questions or comments, please type into the chat box at the bottom left corner of your screen. Your responses will be addressed during the audience discussion later on in the webinar.

Polling Question

What is your organization currently doing to minimize infections, such as CAUTI, CLABSI, and VAP?

Polling Question

In your organization, what is the principle barrier to reducing infections in the intensive care unit?
Reactor Panel Discussion

Moderated by Steve Findlay
NPP Partner

Frontline Provider Perspective

Michael Klompas, MD, MPH
Associate Hospital Epidemiologist
Brigham and Women’s Hospital

The VAP Prevention Paradox

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A Cautionary Tale...

Unit by Unit Ventilator Bundle Compliance Report

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On investigation—Daily sedation holiday and readiness to extubate marked as “contraindicated” in ~50% of patients
Consumer Advocacy Perspective

Victoria Nahum
Executive Director
Safe Care Campaign

Just as Dr. Pronovost’s successful Checklist Approach requires that certain components be in place in order to realize best expected outcomes, certain components must be in place within a Patient-Centric / Patient-Involved Safety Culture in order to realize best expected outcomes.

“Checklists have a role in improving patient safety. But they only get us part way down the field. To reach our ultimate goal - making patients safer - we must engage teams to embrace the concepts behind checklists and become full partners in developing and improving this life-saving tool. And, we must measure our results to make sure that every patient always gets the care they deserve.”

– Peter Pronovost

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The 3 E’s.

Actual harm to the patient can and probably will be caused by lack of any of these 3 components.

Lacking these necessary components, healthcare will never completely attain the highest levels of best outcomes we aspire to.

We cannot begin to call what we currently have “A True Culture of Safety” until we incorporate these components into every care plan for every patient.

Patient and Family Engagement
Patient and Family Education
Patient and Family Empowerment

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Health System Perspective

Approach from MemorialCare

Helen Macie, Pharm.D., FABC
Senior VP, Performance Improvement and Strategy
MemorialCare Health System, Southern California

The Four Keys

- Make it Strategic
  - Set "Bold Goals"
  - Reduce Hospital Acquired Infections (HAIs) to the Zero Zone by June 2012

- Hand Hygiene
  - Standardize definition
  - Marketing campaign
  - Training for ALL
  - Champions, surveillance
  - Amnesty’s over

The Four Keys

- Hard-Wired Best Practices
  - System-wide HAI Best Practice Team
  - Gap analysis to evidence
  - Tests of change
  - Hard-wiring into EMR

- Results Visibility
  - Board, e-dashboards, committees, department visibility boards
  - Talk about rates and #s
    - 187 Lives latched, reduced infections
    - ~$2.1M/year saved
Questions for the Panelists

1. In your work, how have you actively engaged patients and families to prevent infections?

2. What is your advice for webinar participants who want to accelerate change and achieve success?

3. What policy or environmental supports are needed to accomplish your goals?

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Audience Discussion

Tell us about your experience in reducing infections in the ICU

To provide questions or comments, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 1-888-203-7337, confirmation code 9168748, and press *1 to ask a question.

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Polling Question

Does your organization have a system in place for educating patients and their families about their role in reducing infections?

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Scenario Polling Question

A patient is in the ICU with a complex condition. His brother and nurse are waiting for the physician to check on him. When the doctor enters the room, she forgets to wash her hands. What is most likely to happen next, in your hospital?

Audience Discussion

Talking About Your Experience

To provide questions or comments, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 1-888-203-7337, confirmation code 9168748, and press *1 to ask a question.

Conclusion

Next Steps, Further Resources, and Concluding Remarks
Polling Question

When do you plan to act on the information provided in this webinar?

Polling Question

Did you find tangible actions and practices you can put to use in your organization or community in this webinar?

Further Resources

Resources, links and PDF documents are available now in the top left corner of your screen, including:

- Partnership for Patients website
- National Priorities Partnership website
- National Quality Forum patient safety webpage
- Link to the John M. Eisenberg Patient Safety and Quality Award – Application period open from Aug. 1 – Oct. 3
Patient Safety Webinar Series

Upcoming webinar topics:

- Surgical Site Infections – August 16
- Pressure Ulcers and Injuries from Falls – September 9
- Obstetrical Adverse Events – September 28
- Venous Thromboembolism - October 5

To register: eo2.commpartners.com/users/pfp/

Concluding Remarks

Steve Findlay, NPP Partner

Thank You

A recording of this webinar will be available on the National Quality Forum website within 48 hours. When you exit, you will automatically be directed to an evaluation about this webinar.

For further questions, please contact priorities@qualityforum.org