

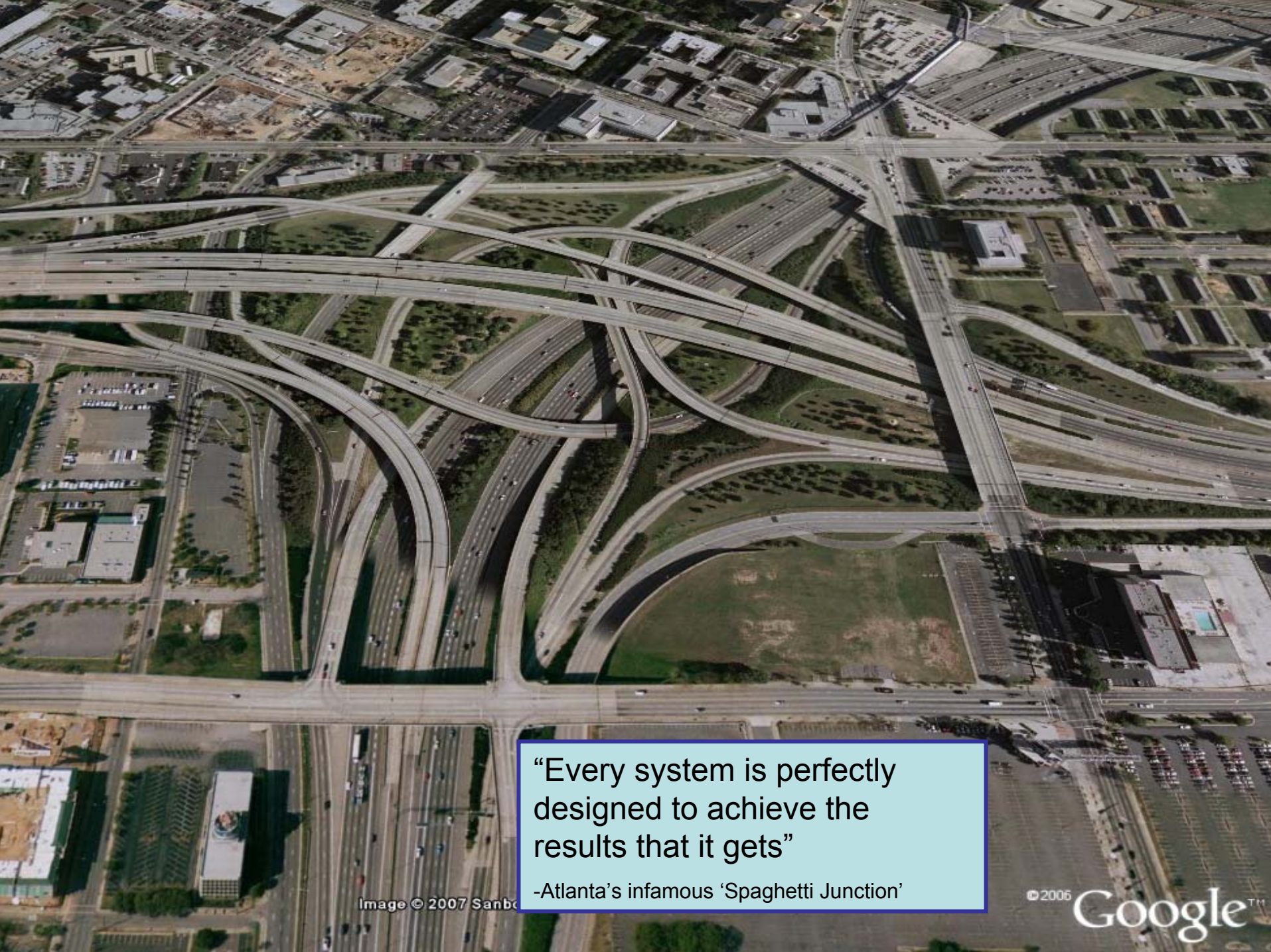


Improving the Rate of HAI Will, Ideas, and Execution

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“Every system is perfectly designed to achieve the results that it gets”

-Atlanta's infamous 'Spaghetti Junction'

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- Who is responsible for preventing HAIs?

IS THERE WILL TO CHANGE?

- Who needs to be accountable and for what?

IS THE SYSTEM CAPABLE?

- How to get physicians engaged

A HELPFUL MODEL

The way to success...

- Establish the **WILL** for change
- Identify superior, evidence-based **IDEAS**
- Develop a **EXECUTION** strategy

The Model for Improvement

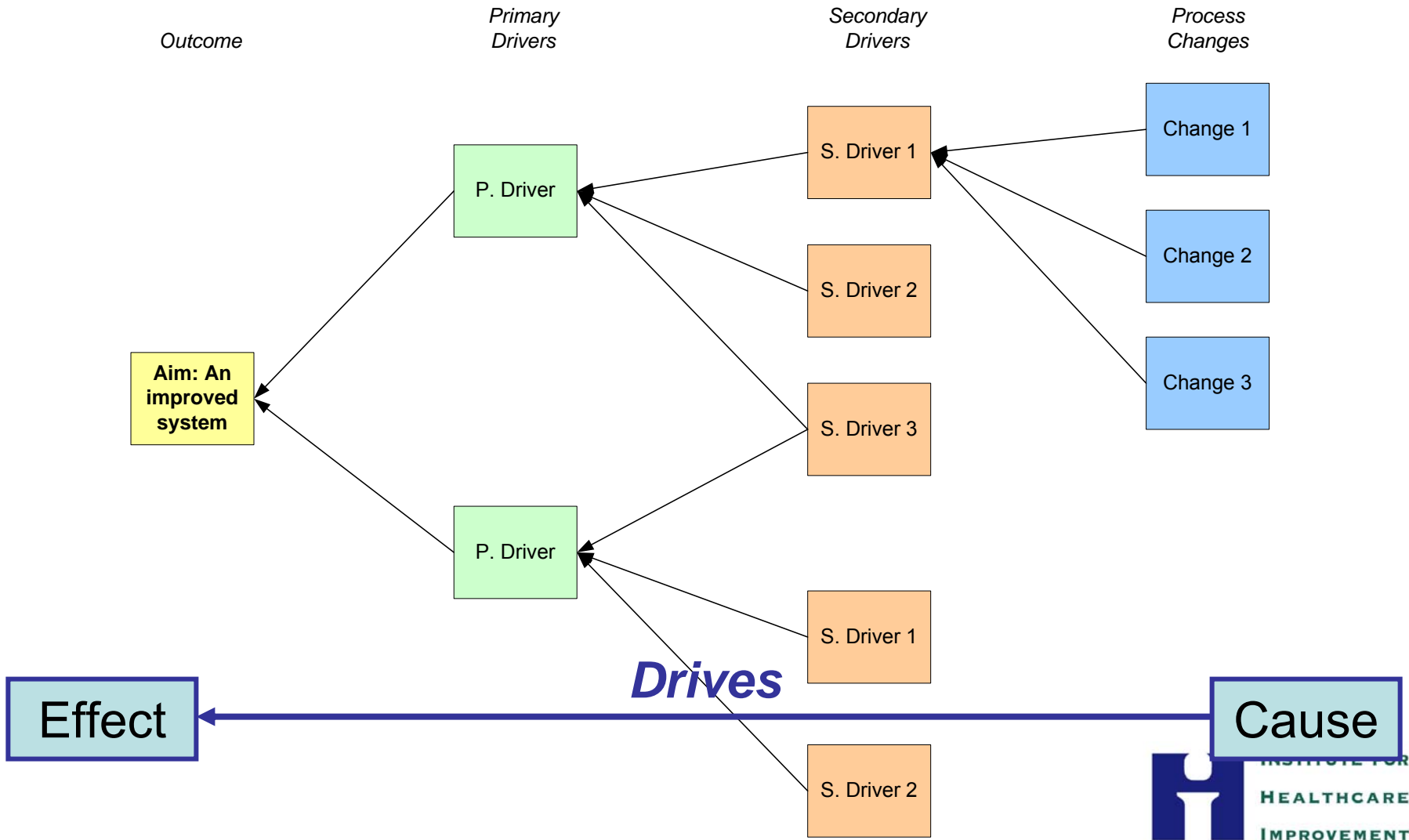
1. What are we trying to accomplish?
2. How will we know a change is an improvement?
3. What changes can we make that will result in improvement?

Building Will

- In God we trust, all others bring data
- Incentives and punishments
- Culture of expectation
- Pride and duty

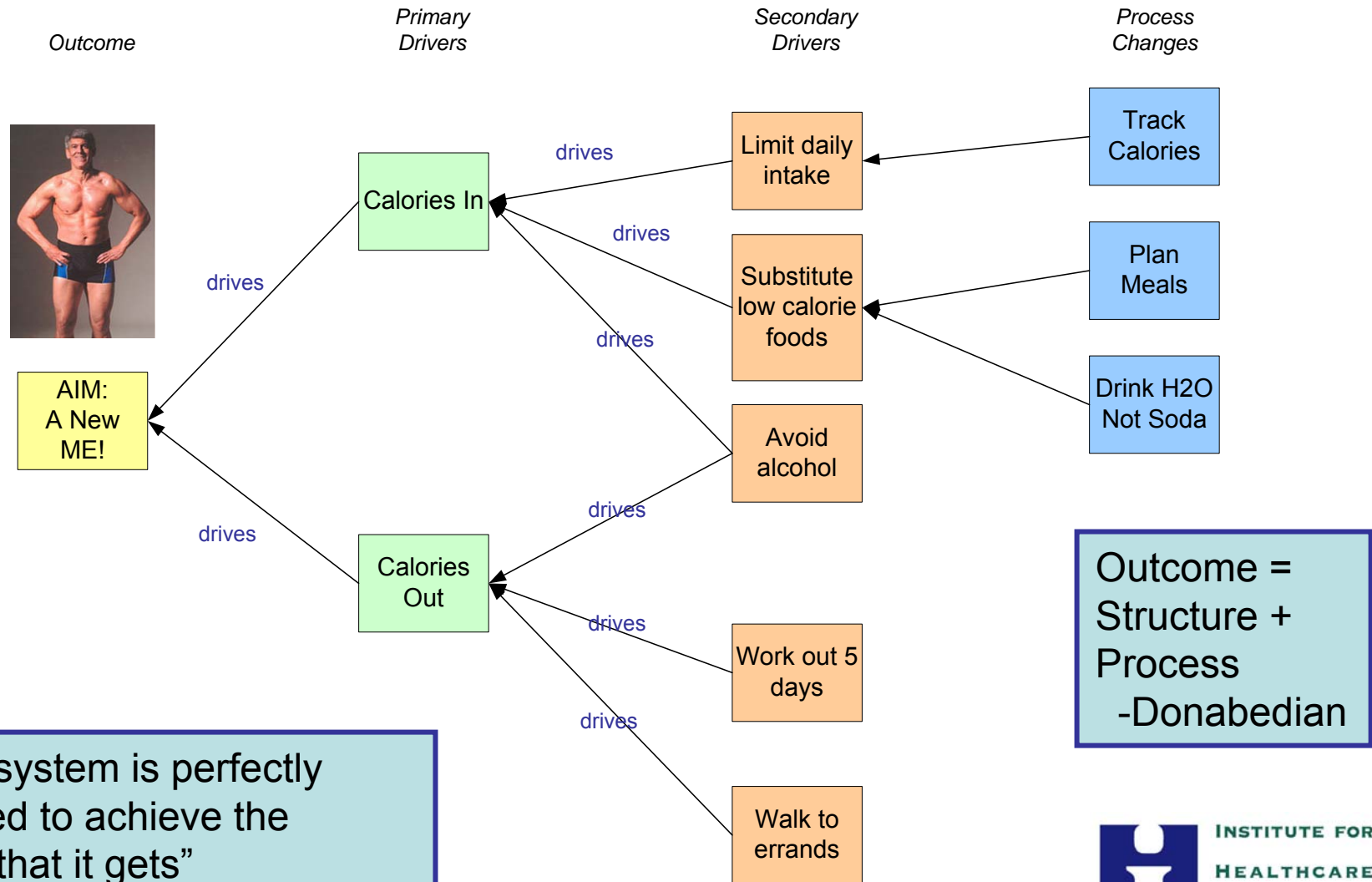
What Changes Can We Make?

Understanding the System



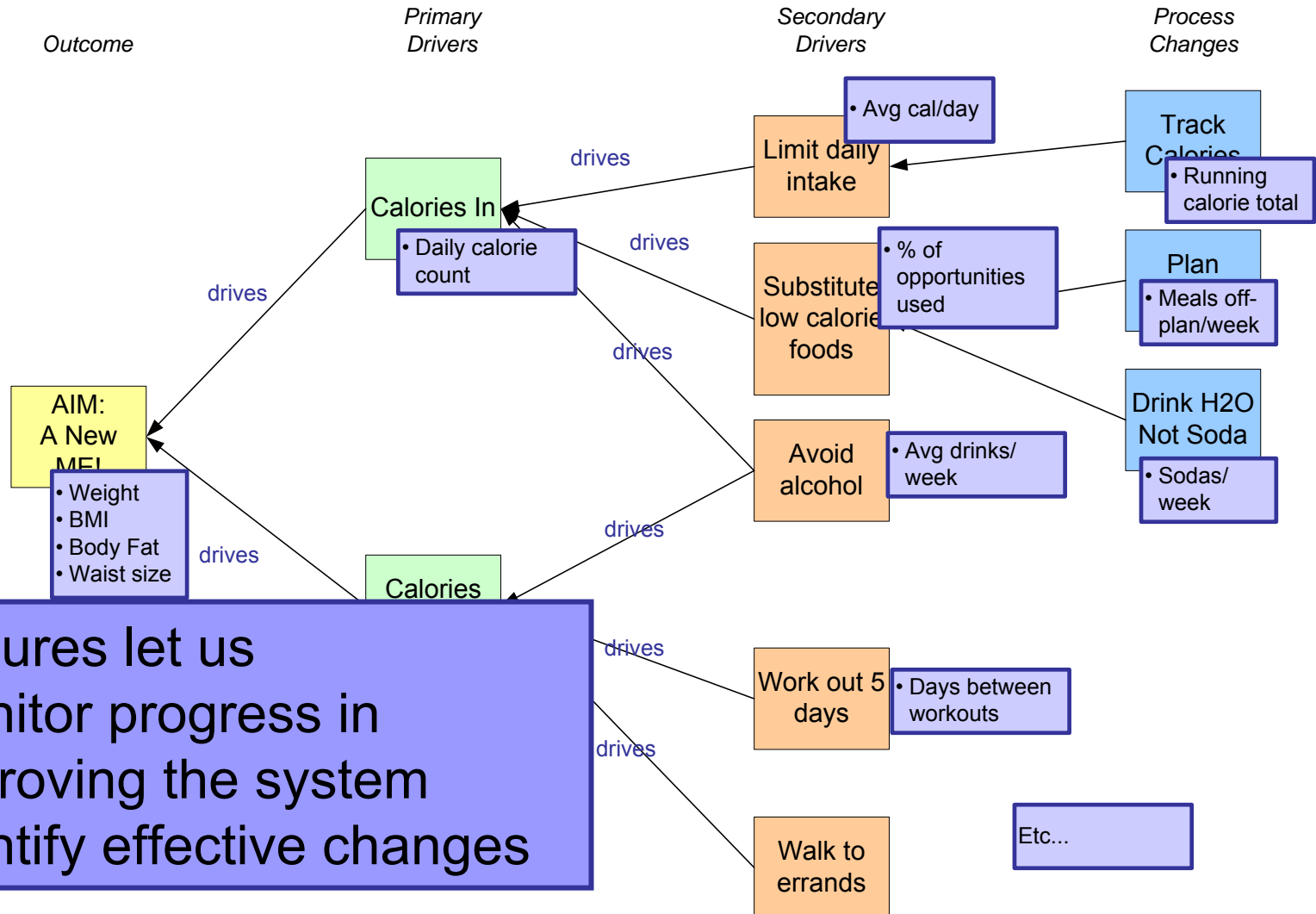
What Changes Can We Make?

Understanding the System for Weight Loss



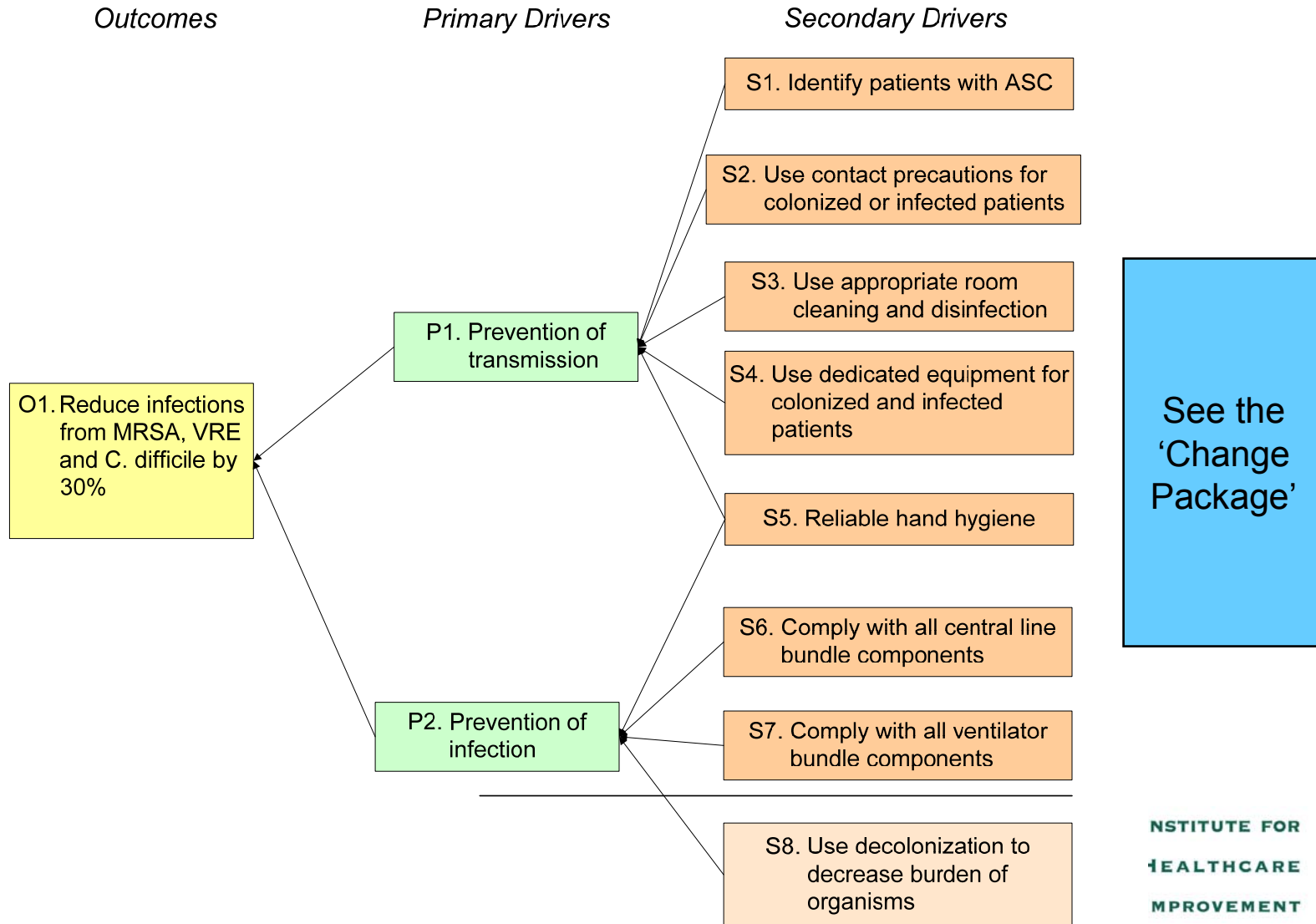
How Will We Know We Are Improving?

Understanding the System for Weight Loss with Measures



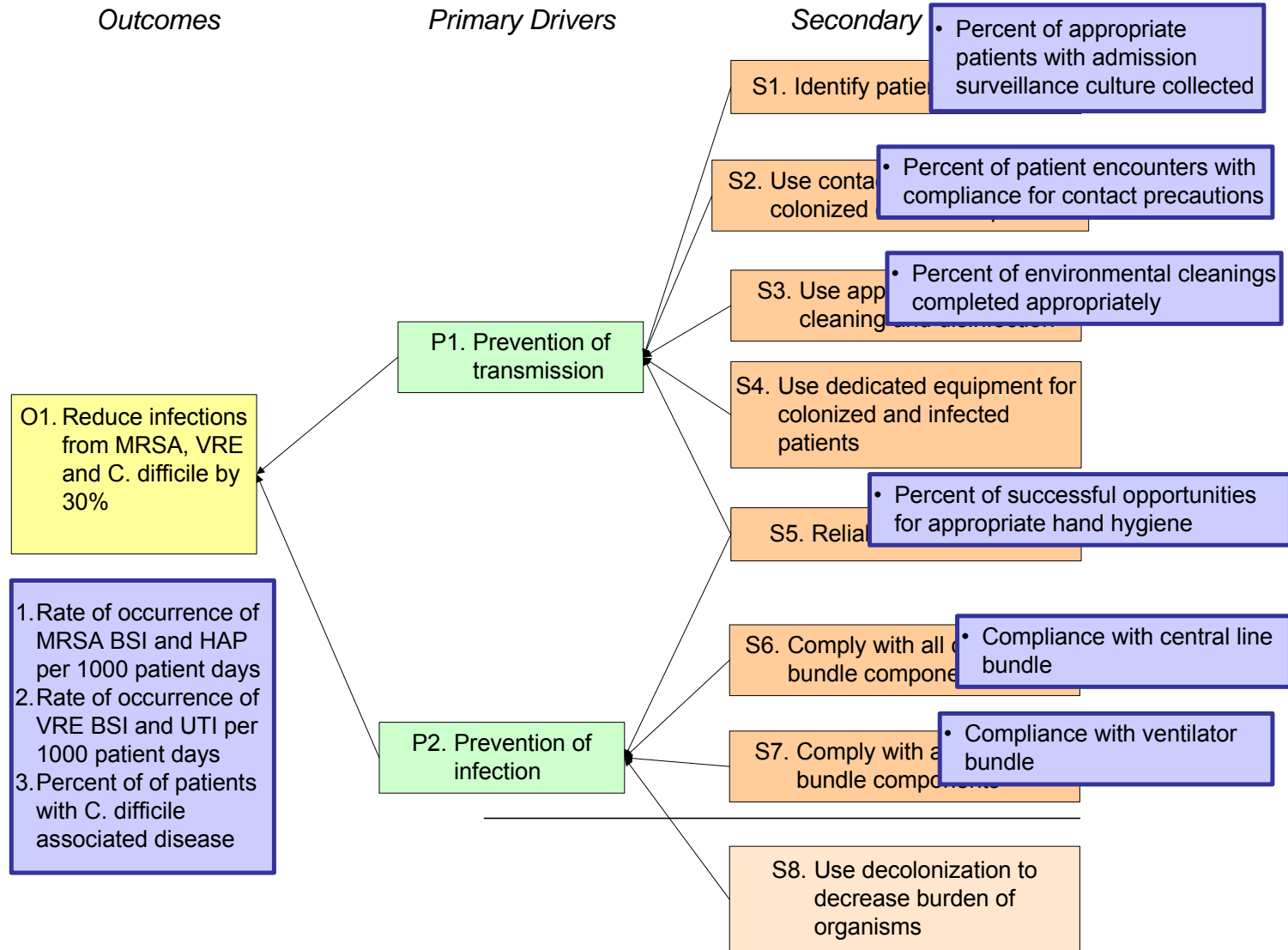
What Changes Can We Make?

Understanding the System for Reducing Hospital Acquired Infections



How Will We Know We Are Improving?

Understanding the System for Reducing Hospital Acquired Infections with Measures



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HAI Measures

No	Measure	Required	Type	Goal	Driver or Outcome Targeted
1	Rate of occurrence of MRSA BSI and HAP per 1000 patient days	Select one*	Outcome	Reduce by 30% from baseline	O1. Reduce infections from MRSA, VRE and C. difficile
2	Rate of occurrence of VRE BSI and UTI per 1000 patient days		Outcome	Reduce by 30% from baseline	O1. Reduce infections from MRSA, VRE and C. difficile
3	Percent of of patients with C. difficile associated disease		Outcome	Reduce by 30% from baseline	O1. Reduce infections from MRSA, VRE and C. difficile
5	Percent of successful opportunities for appropriate hand hygiene	No	Process	Reduce by 50%	S5. Reliable hand hygiene
6	Percent of appropriate patients with admission surveillance culture collected	No	Process	Reduce by 50%	S1. Identify patients with ASC
7	Percent of patient encounters with compliance for contact precautions	No	Process - All or None	Reduce by 50%	S2. Use contact precautions for colonized or infected patients
8	Percent of environmental cleanings completed appropriately	No	Process	Reduce by 50%	S3. Use appropriate room cleaning and disinfection
9	Compliance with central line bundle	No	Process - All or None	Close gap by 50%	S6. Comply with all central line bundle components
10	Compliance with ventilator bundle	No	Process - All or None	Close gap by 50%	S7. Comply with all ventilator bundle components

HAI Change Package

Reducing Hospital Acquired Infections IMPACT Community Change Package 2007-2008

Secondary Driver	Ideas for PDSA testing	Suggested "mini-measures" for PDSA testing
S5. Reliable hand hygiene	0. Pre-change activities: Build knowledge about infection, transmission principles, hand hygiene, and hand washing technique.	Percent of a random sample of 10 front-line staff who can describe transmission principles and techniques
	0. Pre-Change Activities: Design processes and create infrastructure to support reliable hand hygiene.	Percent of a random sample of 10 front-line staff who can describe procedures for reporting needed supplies
	1. Create a culture that supports reliable hand hygiene. Suggested changes:	Opinion leaders and staff report discussion and modeling
	2. Use reminders at the point of care. Suggested changes:	Measure # 5: Percent of patient encounters with appropriate hand hygiene
	3. Monitor & provide feedback about performance. Suggested changes:	Percent of a random sample of 10 staff who are aware of handwashing compliance
S1. Identify patients with ASC	1. Identify patients who will be cultured. Possible alternative strategies include:	Percent of patients appropriately identified
	2. Design and test a reliable process to obtain cultures and transmit them to the lab. Possible changes include:	Percent of applicable admission for whom culture was received at lab
	3. Design and test reliable and timely processes for processing the cultures and notification of results. Planning activities and changes include:	Percent of cultures processed within 24 hours
	4. Take appropriate action when tests are positive	Percent of patients for whom

OR
RE
NT



Engaging Physicians

1. Discover Common Purpose:

- 1.1 Improve patient outcomes
- 1.2 Reduce hassles and wasted time
- 1.3 Understand the organization's culture
- 1.4 Understand the legal opportunities and barriers

6. Adopt an Engaging Style:

6.1 Involve doctors from the beginning

6.2 Work with the real leaders

6.3 Work with early adopters

6.4 Make physician involvement visible

6.5 Build trust within each quality initiative

6.6 Communicate candidly, often

6.7 Value physicians time with your time

5. Show Courage:

5.1 Provide Backup all the way to the Board

4. Use "Engaging" Improvement Methods

4.1 Standardize what's standardizable, and no more

4.2 Generate light, not heat, with data

4.3 Make the right thing easy to try

4.4 Make the right thing easy to do

2. Reframe Values and Beliefs:

2.1 Make physicians partners, not customers

2.2 Promote both system and individual responsibility for quality

3. Segment the Engagement Plan:

3.1 Use the 20/80 Rule

3.2 Identify and activate champions

3.3 Educate and inform structural leaders

3.4 Develop project management skills

3.5 Identify and work with "laggards"



Reference

Reinertsen JL, Gosfield AG, Rupp W, Whittington JW.

Engaging Physicians in a Shared Quality Agenda.

IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org)



Using the 5 Million Lives as a Launch



Winning Execution Strategies

- Pick a patient segment upon which to test
- Work with those who want to work with you
- Small tests of change, small tests of change, small tests of change
- Learn as you go: develop process for review and improvement
- Encourage customization



What Does The Evidence Tell Us?

- Rational Interventions Should Target **Modes of MRSA Transmission**
 - Person-person via hands of health care providers – **by far the most important**
 - Personal equipment (e.g., stethoscopes, PDAs) and clothing
 - Environmental contamination
 - Airborne transmission
 - Carriers on the hospital staff
 - Rare common-source outbreaks



Prevent Infection *and* Colonization

- Colonized patients comprise the reservoir for transmission (“colonization pressure”)
- High rates of MRSA colonization complicate empiric antibiotic therapy (e.g., vancomycin)
- Colonized patients have a high rate of MRSA infection
 - Nearly 1/3 develop infection, often after discharge
- Colonization is long-lasting, and patients can transmit MRSA to patients in other health care settings (e.g., nursing homes), as well as to family members

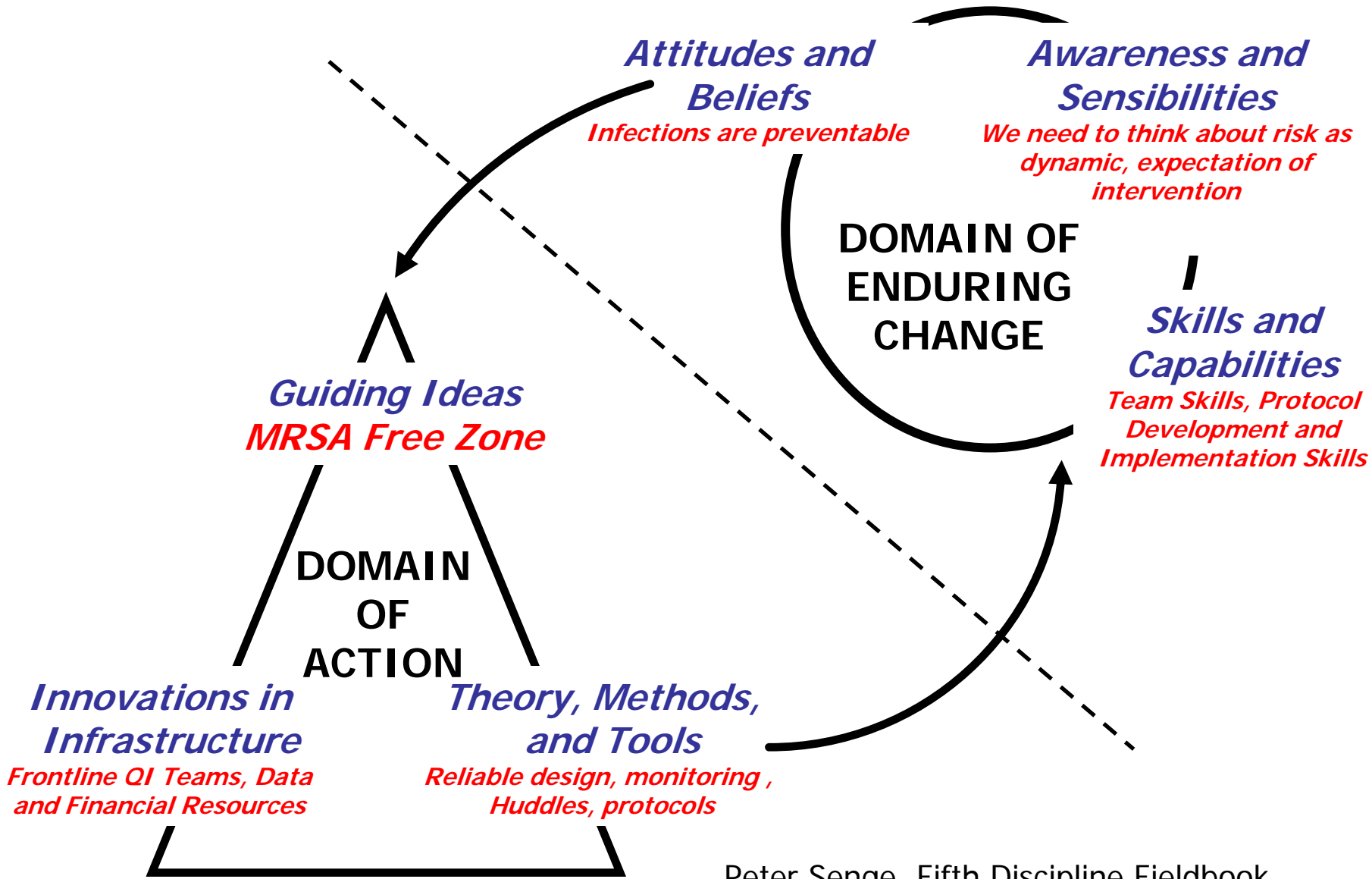


Five Key Interventions

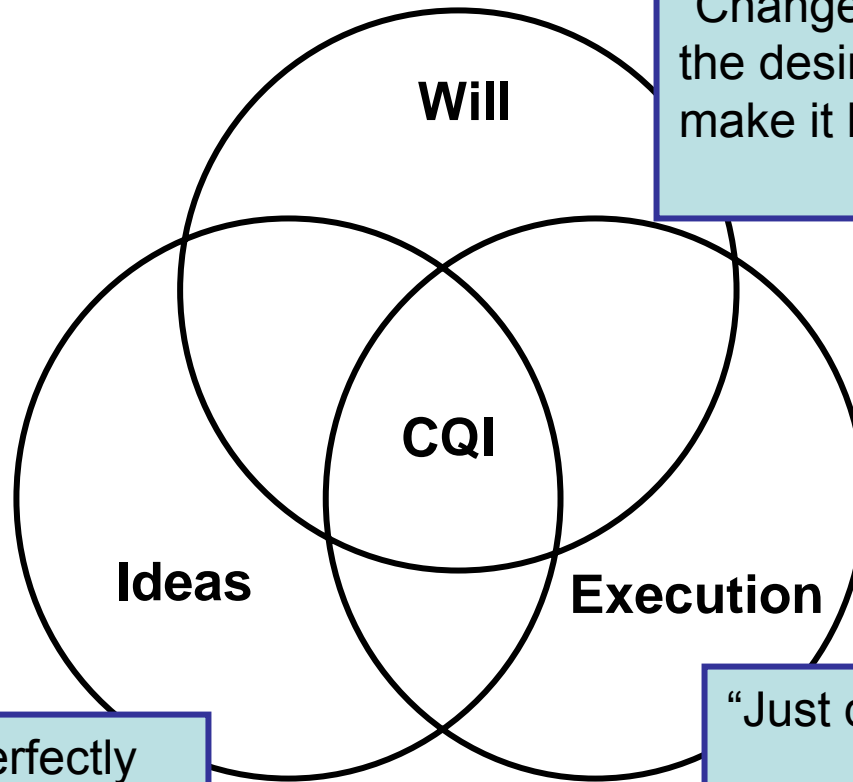
- Hand hygiene
- Decontamination of the environment and equipment
- Active surveillance cultures (ASCs)
- Contact precautions for infected and colonized patients
- Compliance with Central Venous Catheter and Ventilator Bundles

Causes of failure in making transformational change

- Not establishing a sense of urgency
- Not forming a powerful enough guiding coalition.
- Lacking a vision
- Undercommunicating the vision by a factor of ten.
- Not removing obstacles to the new vision
- Not systematically planning for and creating short term wins
- Declaring victory too soon.
- Not anchoring the changes in the corporation's culture.



What It Takes to Improve a System



“Change is possible if we have the desire and commitment to make it happen.”

- Mohandas Gandhi

“Every system is perfectly designed to achieve the results that it gets.”

-Paul Batalden

“Just do it.”

- Nike