



Peter Pronovost talks to team members from the Illinois Health Association.



## Insurers Credit Illinois Hospitals

Illinois Provider Trust (IPT) -- a self-insurance program that serves 33 Illinois hospitals -- has offered members who participate in the On the CUSP: Stop Bloodstream Infections (BSI) project a 1 percent credit on their 2010 contribution. "This kind of partnership is just what we want to see as we spread this program nationally; I hope other states follow this lead," says Peter J. Pronovost, M.D., Ph.D, co-investigator of the On the CUSP: Stop BSI program and director of The Johns Hopkins University's Quality and Safety Research Group.

The Illinois Hospital Association (IHA) has a long history of supporting innovative patient safety programs such as On the CUSP: Stop BSI. Since 2005, member hospitals have addressed medication reconciliation, safe hand-offs, reducing injuries due to falls, reducing pressure ulcers and lowering catheter-associated urinary tract infections, says Becky Steward, IHA's director of patient safety. "There has been a tremendous response from hospitals and a strong

commitment to the BSI initiative," says Steward. By partnering with Hopkins, IHA was able to expand the collaborative to a larger number of hospitals, principally because of resources JHU makes available for database support and analysis."

Cheryl Church, senior director of risk management for Illinois Risk Management Services IRMS (a subsidiary of the IHA that helps provides claims and risk management services for the IPT) says IPT traditionally has offered up to a 5 percent credit to any member hospital that complies with a list of progressive safety initiatives proven to reduce hospital errors and lower costs. However, this is the first time IPT has chosen one safety initiative and offered an additional 1 percent credit. Church says they singled out the BSI initiative because its success in Michigan highlighted how effective the program is at saving lives and lowering costs associated with hospital-borne infections. She says the IPT

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### PROJECT AT A GLANCE

- 28 States
- 27 State Hospital Associations
- Nearly 40 partner organizations
- Over 150 conference calls
- 23 Launch Meetings
- No entries on the project blog
- #1 request: How do we get our physicians on board?
- #2 request: Can we get a few pictures with Peter?

## Message From John Combes



John Combes, co-investigator  
On the CUSP: STOP BSI

Implementing patient safety and quality improvement practices have been a challenge for health care providers.

Even when the best evidence is available—as in the case of preventing certain health care associated infections—translating that evidence into clinical practice is prevented by our attitudes, behaviors, and the organization of our work units.

The Comprehensive Unit-based Safety Program (CUSP) developed by Dr. Peter Pronovost and his team at The Johns Hopkins University

Quality & Safety Research Group has successfully overcome those barriers by providing a template for unit-based cultural transformation in the way we accomplish our daily work.

Combined with evidence-based infection prevention techniques, CUSP has already demonstrated its effectiveness in eliminating central-line-associated blood stream infections (CLABSI) in over half of Michigan hospital ICUs that participated in a 2003 AHRQ funded Keystone

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*“Building state-level capacity in the evidence-based CUSP model and CLABSI elimination techniques is the overarching goal of this initiative.”*

*John Combes*

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## Message From Peter Pronovost



Peter Pronovost, co-investigator  
On the CUSP: STOP BSI

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*“We have  
found a way  
to make patients safer.”*

*Peter Pronovost*

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Nearly ten years ago the Institute of Medicine shocked the nation with its influential report on hospital errors and patient harm, “To Err is Human.”

Since that report little has changed. In fact, current estimates suggest that more than 200,000 people die needlessly each year from diagnostic errors or the failure of patients to receive recommended therapies.

However, there is hope on the horizon. We have found a way to turn those numbers around. We have found a way to make patients safer.

That way is the On the CUSP: Stop BSI project and we are depending on your leadership to make see it through. You are part of a project that will save lives and make history, a project that will lead to the first empiric and measurable im-

provement in safety throughout the country, a project that will be the polio campaign of the 21st century.

It will not be easy. No one has done this before. There will be challenges and resistance. It will require effort to collect valid data. Yet our patients deserve nothing less.

No one group can do this alone, it will require collaboration between hospitals and state hospital associations, physicians and nurses, health departments and quality improvement organizations, senior hospital leaders and infection preventionists, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality. Amazingly, all of these groups are already collaborating. Yet remarkably, hospitals have been

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The QSRG home team at work in the Baltimore office on Thames Street

## What Exactly Does QSRG Mean And Who Are We?

The QSRG is a small group of health services researchers in the School of Medicine at Johns Hopkins University. We have a lot of friends who share our commitment to improving health care, and they visit often.

On Tuesdays, we hold a research team meeting that draws the intellectually curious to our conference room on the Inner Harbor. Students, faculty, and guests, come from across the University and around the world.

We think big thoughts, shoot holes in

each others ideas, challenge ourselves to be creative yet rigorous and to never forget that patients are the main purpose for all that we do.

If you plan to be in Baltimore on a Tuesday, let us know. The meetings are open and you are now part of work that we believe will change the way our nation thinks about improving quality and patient safety.

We are so happy you are sharing this journey with us.

*OHANA*

### Illinois ...

Board, which is made up of CEOs and CFOs from member hospitals, believes this program will provide an excellent shared learning opportunity that will benefit participants by improving communication, promoting a culture of safety, and reducing the risk associated with hospital-acquired infections.

“Basically the board thought this was a good program; why not reward our members who participate? It will only help to better improve patient safety and reduce risk,” says Church. Church says hospitals won’t get the credit simply because they sign up for the program. They have to show compliance.

She said IPT gives hospitals helpful detailed guidelines for how to comply

with criteria so they can qualify for credit. To confirm compliance they visit each hospital once a year and do an assessment. The extra 1 percent can add up to thousands of dollars for some hospitals, according to Church. “It works out well for many hospitals because this more than covers any expense they might incur putting the program in place,” she says.

Steward says IHA chose the BSI project because it’s good evidence-based practice. There has been a lot of emphasis on infections and this program went hand-in-hand with infection control risk criteria. “It just seemed like an excellent learning opportunity for our hospitals,” says Steward.

### PARTICIPATING STATES

ARKANSAS  
 CALIFORNIA  
 COLORADO  
 CONNECTICUT  
 FLORIDA  
 GEORGIA  
 HAWAII  
 ILLINOIS  
 INDIANA  
 MASSACHUSETTS  
 MINNESOTA  
 MISSOURI  
 NEBRASKA  
 NEW HAMPSHIRE  
 NEW JERSEY  
 NEW YORK  
 NORTH CAROLINA  
 OHIO  
 OKLAHOMA  
 OREGON  
 PENNSYLVANIA  
 SOUTH CAROLINA  
 TENNESSEE  
 TEXAS  
 WASHINGTON  
 WEST VIRGINIA  
 WISCONSIN

## IN THE NEWS

The On the CUSP: STOP BSI team has announced that the project is expanding beyond the 10 HRET sponsored states and the 18 Johns Hopkins sponsored states.

Recruitment has varied by state to include ICUs, non-ICUs, and critical access hospitals.

The project has been launched via face-to-face meetings that started in May and will continue through mid November. These meetings have taken place in 20 of the 27 states, as of October 5. Enthusiastic leadership by state leaders has inspired strong communication and productive feedback.

In addition an On the CUSP: Stop BSI blog has been established to further facilitate the creation of a network among state leads and project participants to share information, comments, and suggestions.

Visit the  
On The CUSP  
Stop BSI  
Web Site at:  
[www.safercare.net](http://www.safercare.net)

## Lessons We Learn From Bees

Swarms of honey bees, it turns out, have an uncanny ability to select the best location for a new hive. And the traits that help them make decisions could also help the health care community make better choices.

When a swarm needs a new home, hundreds of bees explore potential locations. Upon returning, these scouts perform a —waggle dance to indicate their ratings of a site's quality.

As the dancing builds, scouts test locations promoted by others and bring back their own reports. Eventually, a consensus emerges.

While scientists have long known about the bees' decision-making acumen, a recent article explains why their process works so well: It demands both independence—the scouts' objective assessments of locations—and interdependence—advertising their findings to others, testing it for themselves, and sharing — waggling — what they think. Using computer simulations of bee behavior, the researchers discovered that poor performance in these behaviors undermined the swarm's success.

Investigating sites without advertising them caused the selection process to slow down dramatically, leaving the bees homeless; while blindly heeding others' initial recommendations without independently evaluating these sites created quick decisions that frequently missed the best choice.

There are strong parallels to this phenomenon in patient safety efforts. Traditionally national safety goals and safe practice recommendations have been made by a small group of well-intentioned people,



most of whom do not practice medicine. And few if any of these recommendations have been tested. Similarly, the medical community lacks a mechanism to share its perceptions about what works and where it is most effective.

Consider the best-practice guidelines issued by medical professional societies and government agencies, which may contain hundreds of pages and 100 recommendations in such areas as preventing infections.

Are the guidelines practical in every clinical situation? Are any ambiguous? How can caregivers follow them all? It's no wonder that the widespread adoption of guidelines often takes a couple decades, if it occurs at all.

This is what makes our work different. Like bees we communicate and share our ideas. And like bees we test these ideas before making them hospital policy. It's this level of teamwork and communication that is the key to the success of the On the CUSP: Stop BSI project. It all comes down to the individual bees, the clinicians, you and I.

Like bees we are interdependent not independent, cooperative not combative. The future of health care and the safety and of our patients depend on it, on our waggle dance.

See a waggle dance at: <http://www.youtube.com/watch?v=4NtegAQpSs&feature=fvwa> and <http://www.pbs.org/wgbh/nova/bees/dancesbees1.html>.

## Combes ...

ICU project of the Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality.

In 2008, the Health Research and Educational Trust (HRET) of the American Hospital Association was awarded a contract from the Agency for Healthcare Research and Quality (AHRQ) to implement and test nationally the highly successful Keystone ICU project in at least 100 hospitals in 10 states over a three-year period.

Last month, HRET was awarded a

contract modification to include all 50 states, the District of Columbia, and Puerto Rico.

State hospital association staff and their participating ICU teams are receiving comprehensive education and training in the CUSP model and CLABSI elimination over a two-year period. Building state-level capacity in the CUSP model and CLABSI elimination techniques is the overarching goal of this initiative.

In addition to dramatically reducing

CLABSI, we anticipate that the CUSP program will be applied to other quality and safety interventions and in other areas of the hospital to improve hospital care more broadly and sustainably.

This initiative is focused on a unit-based culture change strategy that empowers bedside clinical staff to apply the best science available and create an environment and culture for achieving measurable results in quality and patient safety.

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*“This project works. Its success is not a scientific question, but a moral one. It may not be an easy road to follow. But there is no question it is the road we must follow. Patient’s lives are at stake. We must persevere, we must do our part and we must contribute what we can.”*

*Peter Pronovost*

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## Pronovost ...

slow to enroll with their state hospital associations. In many states fewer than 20 percent of hospitals have volunteered to participate.

The reasons are in some ways understandable. Many hospitals say they are using the bundle. Yet rates of central line infections around the country remain high and the culture of safety is poor in most hospitals.

While a handful of hospitals have achieved zero infections, most have not and many do not even collect valid data.

Some academic medical centers say the program does not apply to them; some actively scorn it. They say their patients are too sick, or these infec-

tions are not preventable. However, we have already proven that these statements are not true.

The ICUs at Johns Hopkins and the University of Michigan, both of which care for patients as sick as anywhere in the country, have nearly eliminated these infections. Other hospitals say they have too many other priorities to focus efforts on these infections.

It is true that regulators, insurers and state agencies are inundating hospitals with interventions to improve quality.

Yet central line infections should be on the top of their list. These infections cause the largest number of preventable deaths of all infections

and likely all errors, and we know how to substantially reduce them.

This project works. Its success is not a scientific question, but a moral one. It may not be an easy road to follow. But there is no question it is the road we must follow. Patient’s lives are at stake. We must persevere, we must do our part and we must contribute what we can.

This is your moment. And the patients you care for, the citizens of your state, the entire country are all waiting for you to seize this moment; I hope you do.