

A microscopic view of a blood stream. The background is dark, and the foreground shows a dense population of red blood cells, which are biconcave discs. Interspersed among the red blood cells are several green, spherical bacteria, likely Staphylococcus aureus, which are the cause of bloodstream infections. The bacteria are clustered together and appear to be moving through the blood stream.

2009 IHA Patient Safety Collaborative Stop Blood Stream Infections



Objectives

- Historical perspective
- Johns Hopkins / Michigan Keystone project
- Overview 2009 IHA Patient Safety Collaborative
- Resources

Central line blood stream infections (CLABSIs) are a national problem

Incidence *

- More than 248,000 BSI per year
 - Majority on general units
 - 82,000 ICU
 - 21,000 well baby nursery/high risk nursery
- Over 30,000 deaths
- 25% mortality rate in ICUs
- Consumes billions healthcare dollars

* Klevens, et al., *Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002*, Public Health Reports, at 160-166 (Mar. – Apr. 2007)

Impact on Illinois hospitals in 2008 *

- Est. avoidable cost \$35,000 - 45,000 per infection
- 40,569 avoidable hospital days
- Up to \$59 million avoidable costs
- CLABSI data available to public 2Q2009

* Estimate based on IL Administrative data 1-3Q2008

2005 JHU and Michigan Keystone ICU Project Evidence CLABSIs can be prevented

What was accomplished?

- 127 ICU teams, ICPs, MHA, BCBSMI and JHU
- Achieved and sustained:
 - Statewide median rate < 1 CLABSI / 1000 central line days (zeroing out)
 - Average 66 % reduction CLABSI
 - Improved culture of safety
 - Estimated savings first 18 months = 1,729 lives and \$246 million

JHU and Michigan Keystone ICU Project

- Low tech – 5 steps
- Proven tools
- Consistent guidelines
- Standardized measurement and reporting
- Data analysis and feedback
- Supported by physicians
- Initial spread - IHI 100,000 Lives Campaign

Prevention of CLABSI now national priority

Current environment

- Regulatory compliance/standards for accreditation
 - CMS, IDPH, JC, AOA, NIAHO
- JC NPSG 07.04.01
- IL Hospital Report Card Act (ICUs only)
- Public reporting and data transparency
- Congressional investigation – the Waxman Report
- Designated priority by HHS Catherine Sebelius
- Commitment to prevention of HAI in American Recovery and Reinvestment Act of 2009 (ARRA)

Pay for performance

Present on admission (POA) and Hospital acquired conditions (HAC)

- CMS – reduction in payment
- Medicaid
- Private payers

Not limited to ICUs

Future = bundling of payments for care across continuum

Strategy identified within Waxman Report*

- CLABSIs are almost entirely preventable if state associations implement programs to promote preventative measures
- If all state hospital associations were to implement the MHA/JHU program and achieve the same results
 - 15,680 lives could be saved each year
 - Up to \$1.3 billion could be saved each year

* United States House of Representative Committee on Oversight and Government Reform, *Survey of State Hospital Association: Practices to Prevent Hospital-Associated Bloodstream Infections*, Sept. 2008

Timely solution

- “On the CUSP - Stop Blood Stream Infections”
- National initiative led by Johns Hopkins University and Michigan Keystone Center for Patient Safety
- Includes Comprehensive Unit Safety Program (CUSP)
- 28 state hospital associations, 3 cohorts
- Endorsed by national organizations (CDC, NQF, IHI, APIC, SHEA)
- Recognized as quality improvement strategy – Include in your meeting minutes
- Does not require review and approval by [IRB](#)
- Streamlined reporting

Overview 2009 PSC

- Expert faculty: JHU and MI Keystone Center
- Focus on CLABSI and culture of safety
- Distance-based learning
- Immersion calls + webinars available on-line 24/7
- All-state meeting August 17, 2009
 - In-person or videoconference
 - Recorded / available on-line
- Monthly calls, regional meetings, site visits
- 2 year commitment / 2 years support

Overview of participants

- 42 Hospitals
 - 20 small and rural
 - 22 urban and community hospitals
 - [Statewide](#) participation
- Critical access to academic medical centers
 - 33 with intensive care units
 - 9 without intensive care units
- Varying degrees of implementation and spread

Overview – Commitment by participants

- Implement each intervention over course of PSC
- Collect data per CDC definitions and measures
 - (# CLABSIs / # central line days)
 - Reporting highly encouraged
 - Real-time feedback
- Participate in calls for coaching and problem-solving
- Facilitate development of peer network
- Team will include senior executive, physician champion, nursing champion, ICP, bedside staff, QI staff
- Complete/submit monthly checklist

PSLC begins with series of immersion calls

- [Schedule](#) and content
- Presentations and resources www.safercare.net
- Access 24/7, no password required
- Encourage multidisciplinary participation
- Questions for JHU faculty may be:
 - Submitted in advance to state coordinator
 - Email: Bsteward@ihastaff.org
 - Phone: 630-276-5585
 - Submitted electronically during call

Sequence of Activities 2009 – 2010

- July – August, 2009** Immersion calls
- August 17, 2009** [All-state meeting](#)
Faculty - JHU and MI Keystone Center
- September** Begin collection of data
- September – April, 2010**
Monthly calls/webinars
Regional meetings
Site visits to each hospital
- May, 2010** All-state meeting /date and location TBD

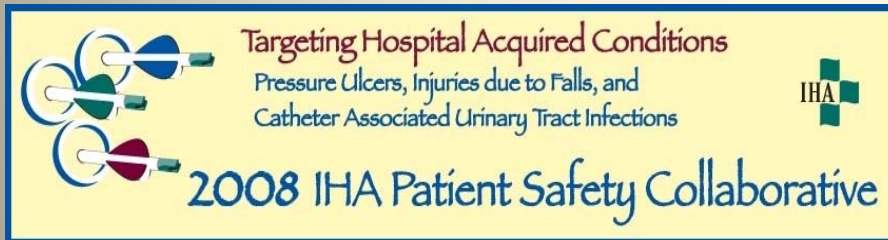
Patient / Family Involvement

Preparing patients and families to live with a central line

- In a health care setting
- In the community

Our goal: [The empowered patient](#)





IHA Patient Safety Collaborative

- Mature, effective infrastructure for improvement
- Expertise in leading patient safety initiatives
- Recognized in BCBSIL Quality Survey 2006, 2007, 2008



**For questions, or
to arrange your site visit, contact:**

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