FALL 2010

Quality Quarterly

A publication of the Illinois Hospital Association Quality Care Institute

Welcome

Welcome to the inaugural issue of *Quality Quarterly*, the IHA Quality Care Institute's new publication, designed to inform, inspire and support hospitals and health systems on their journey to make Illinois a national leader in quality care and patient safety. It was just over a month ago when we publicly announced our campaign, ***Raising the Bar: A Call to Action***. Nearly 200 hospital and health system leaders across the state signed the pledge and joined this unprecedented initiative to share best practices and engage in specific interventions over the next three years to reduce hospital readmissions and hospital-acquired infections and other conditions. The news of our efforts was published by the Associated Press, *Modern Healthcare*, and many other media outlets. And our efforts were lauded by health care leaders across the country.

Quality Quarterly is your newsletter. Each issue will include a best practices feature highlighting two hospitals. This issue features Edward Hospital, Naperville, a 309-bed hospital located in Chicago's western suburbs, and Ferrell Hospital, Eldorado, a 25-bed critical access hospital in downstate Illinois. Both institutions, while vastly different in size and scope of service, have demonstrated superior performance in dramatically reducing central line-associated bloodstream infections, a key hospital-acquired condition targeted for reduction under our initiative.

Quality Quarterly will also include quality resources, tools and updates on news you can use and upcoming educational programs.

This newsletter will also be distributed to key federal, state and local legislators and policymakers to showcase the collaboration of all Illinois hospitals and our increased efforts to make sure every patient receives the right care at the right time, each and every time.

Please share your thoughts with us.

Maryjane A. Wurth, President
Illinois Hospital Association

Getting to Zero!

Wednesday, November 17, 2010
8:30 a.m. to 3:00 p.m.
Wyndham Lisle Hotel, Lisle

Join national quality experts from the Agency for Healthcare Research and Quality, the Johns Hopkins Quality and Safety Research Group, the Keystone Center for Patient Safety and Quality, and the Health Research and Educational Trust to learn proven strategies to reduce health care-associated conditions at the IHA Quality Care Institute's day-long conference—*Getting to Zero!*

At this meeting, you will:

- Learn best practices from leading experts;
- Get the tools you need to reduce CAUTI and CLABSI infections at your hospital;
- Benefit from motivating presentations and practical approaches to implementing successful interventions; and
- Share strategies to help prevent and avoid health care-acquired infections.

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www.ihaqualitycare.org
1.630.276.5588

Edward Hospital, Naperville

For the past three years, 309-bed Edward Hospital has focused on an initiative to eliminate central line-associated blood stream infections (CLABSI). By implementing successive clinical interventions, Edward's staff progressively reduced the number of CLABSI in its intensive care units. However, implementing "bundles" and "checklists" – while powerful, evidence-based improvement activities – "can only take you so far," says Mary Anderson, MT (ASCP), CIC, Manager of Infection Control. To get to the next level, Edward implemented the Comprehensive Unit-based Safety Program (CUSP), which integrates communication, teamwork and leadership to create and support a "harm-free" patient care culture. CUSP is sponsored by the Agency for Healthcare Research and Quality (AHRQ).

Involvement in the CUSP program has been "transformative" to Edward's improvement efforts, says Ellen Stimac, RN, MS, MBA, Director of Performance Improvement. She credits the hospital's leadership with being good listeners and responders to concerns of clinicians. "Hospital execs helped engage individuals, from trustees to frontline clinicians; they raised organizational awareness of the problem and set the stage for improvement activities."

"Quality of care has been an exceedingly important element for us at Edward. We spend as much time talking about quality of care as we do about financial results. One of our recent successes in quality has been reducing the number of central line infections. I actually went and observed a central line insertion with one of our nurses to highlight how important that was to us."

– Pam Davis,
President & CEO,
Edward Hospital

Left to right: Teri Kaneski, Ellen Stimac, Pam Davis, Dr. Hoda Asmar (Chief Medical Officer), Mary Anderson

According to Teri Kaneski, RN, BSN, Performance Improvement Coordinator, getting the staff educated and trained in CUSP principles was challenging. It was a new way of approaching care delivery, integrating patient safety activities and critical thinking at the unit level. The CUSP program involves five steps that result in an evidence-based patient safety infrastructure. Examples implemented by Edward's staff include:

- **Senior executive partners.** When hospital executives are assigned to improvement teams, the benefits are mutual: unit-based staff members have direct access to leadership, enhancing communication and shared learning; and leaders have firsthand experience with improvement projects, patient and staff needs. This enables leaders to support change, provide resources and remove barriers.
- **Learning from defects.** When an incident of CLABSI occurs, all staff members who provided care are contacted. This keeps the staff informed, and each is asked to share any ideas on ways to improve care.

Edward Hospital's staff has now moved to the next level: greater engagement and increased involvement. The staff reports zero CLABSI in the adult ICU over the past nine months and in their NICU for the past eight months. Now the staff is moving the CUSP Program from the intensive care units to the medical-surgical units.

Ferrell Hospital, Eldorado

Ferrell Hospital, a 25-bed Critical Access Hospital in downstate Illinois, shares a similar improvement story. Although the Comprehensive Unit-based Safety Program (CUSP) was originally designed for patients in critical care units, Ferrell staff believed their patients would benefit from the program as well. Linda Brazell, BSN, Vice President of Nursing and Director of Quality and Risk Management, says, "We did not have a critical care unit, but we did have patients with central lines and sometimes very sick patients, too."

Ferrell Hospital staff created a central line-associated blood stream infections (CLABSI) improvement team in late 2009. At the same time, the hospital initiated staff education and conducted a culture assessment, two key steps in the CUSP program.

Getting the entire staff educated about the CUSP program and the culture of patient safety was a comprehensive task, says Janet Creemens, RN, Infection Control Nurse, and CLABSI Team Nurse Champion. Although about 90% of staff members have taken part in the training, reinforcing the messages of a patient safety culture is ongoing. As a small hospital, the team has daily contact with the staff, and new employees receive training during orientation.

Back row; left to right:
Tom Barry, Eloise Millspaugh, Dr. Samir Abdo
Front row; left to right:
Linda Brazell, Janet Creemens

"Our top strategic priority at Ferrell is quality patient care. My responsibility as CEO is to make sure that our Board of Directors, Medical Staff and Hospital Staff are all on board and committed to this number one priority."

"At Ferrell, our care must pass 'The Mother' standard—Would you bring your mother here for care? We must be able to answer yes to this question in everything we do."

– Tom Barry,
President & CEO,
Ferrell Hospital

According to Eloise Millspaugh, RN, Surgical Circulator, who contributed to the improvements in central line insertion packs, team members examined their culture of safety by surveying clinical and ancillary staff, including midlevel providers, pharmacy personnel and physicians. They looked at the practice of placing central lines and checked to make sure problems with lines were being reported. Assessing their culture is an ongoing quality initiative, focused on identifying potential safety breaches and working as a team to safeguard patient outcomes.

Nearly all central lines are inserted by one surgeon—Dr. Samir Abdo. Reducing variation in the process, standardizing insertion kits, using clorhexidine skin prep, and an emphasis on hand washing have all contributed to zero infections since the beginning of the program in 2009.

After implementing the CUSP program in medical-surgical patient care areas and surgery, Ferrell plans to expand the program to include emergency department admissions.

Resources: For more information, go to www.onthecuspstophai.org

Quality Care Institute Advisory Group Meeting

The IHA Quality Care Institute Advisory Group, consisting of 28 hospital leaders from across the state and chaired by Jim Leonard, MD, President and CEO of Carle Foundation Hospital, Urbana, met on Aug. 16. The following actions occurred:

- A subcommittee on transparency was created, with the immediate charge of developing public information on emergency department, observation care, and outpatient surgical care for display on the Quality website, Illinois Hospitals Caring for You.
- The Advisory Group approved a recommendation by the Informatics Subcommittee on performance feedback that reports be available to hospitals that sign the ***"Raising the Bar"*** pledge. The reports on readmissions and hospital-acquired conditions will include executive level updates; individual hospital control chart data and information; and comparative hospital information. In addition, all hospitals will be asked to send data on readmissions to COMPdata in order to calculate readmission rates by hospital and care condition. About half of the hospitals currently submit the necessary data to COMPdata.
- The next meeting of the Advisory Group will be Nov. 15. Members will discuss the value of implementing the AHRQ Culture of Safety Survey (Survey on Patient Safety-SOPS) and administering it to hospital-based employees.

IHA President *Maryjane A. Wurth*

Senior Vice President, Quality Care Institute
Patricia Merryweather

Senior Director, Quality Improvement/ Clinical Liaison
Tim Philipp, RN, PhD

Produced by the Corporate Communications and Marketing Department

The Midwest Alliance for Patient Safety: A PSO for Providers by Providers

With more than 200 hospitals in Illinois, the opportunity to share, teach and learn from each other's experiences on critical patient safety issues is extraordinary.

With that goal in mind, the Illinois Hospital Association (IHA) and the Metropolitan Chicago Healthcare Council (MCHC) established the Midwest Alliance for Patient Safety (The Alliance), a Patient Safety Organization (PSO) designed to improve patient care and outcomes through the sharing and evaluation of clinical experiences and information. Bringing together the considerable resources and expertise of IHA and MCHC, The Alliance is focusing on improving patient safety through shared learning among participating Illinois providers.

The Alliance presents a perfect opportunity for the hospital community to work collectively for the good of patients. With a goal of 100% participation in The Alliance, The Alliance is pleased to **offer every hospital in Illinois a free membership**. With a membership, hospitals will be able to participate in collaboratives, improvement projects, and education and learning from their peers throughout the state – all in the protected environment of a PSO.

A participation agreement was recently sent to hospitals and can be signed and faxed back to 312-906-6123 or emailed to hrobison@mchc.com. If you have any questions about The Alliance, please contact Pat Merryweather, IHA senior vice president, at 630-276-5588 or pmerryweather@ihastaff.org.

Getting to Zero! *(continued from page 1)*

Conference speakers include:

- ***Julius Pham, MD, PhD,*** Assistant Professor, Department of Emergency Medicine & Department of Anesthesia/Critical Care Medicine, the Johns Hopkins University School of Medicine. Dr. Pham is the lead physician for Illinois on CLABSI.
- ***Kristina Weeks,*** Research Coordinator, the Johns Hopkins Quality and Safety Research Group. Weeks dedicates her research interest on the translation of evidence-based medicine for both effective health policy and safe, high-quality bedside care.
- ***Sam Watson, MSA,*** Executive Director, Michigan Health & Hospital Association (MHA) Keystone Center for Patient Safety and Quality. Watson is responsible for the statewide patient safety collaborative, including the Keystone Hospital-Associated Infections, and works with Blue Cross Blue Shield of Michigan on pay for performance.
- ***Sanjay Saint, MD, MPH,*** Professor of Medicine, University of Michigan Health Systems, Ann Arbor, and Research Scientist, Ann Arbor VA Medical Center. Dr. Saint focuses his research on enhancing patient safety by preventing health care-associated infections, translating research findings into practice and medical decision making.
- ***Christine George, RN, MS,*** ICU Project Manager, MHA Keystone Center for Patient Safety and Quality. George's background is in critical care and peri-operative services. She has held various positions in the hospital setting, including department manager, performance improvement coordinator and risk manager.

Go to www.ihaqualitycare.org for more information and to download a registration form.

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1151 East Warrenville Road
Naperville, Illinois 60566
630.276.5400
www.ihatoday.org

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