“Everything is impossible until someone does it”

Frank Federico
We Exist Because…

“Between the health care we have and the care we could have lies not just a gap, but a chasm.”

- Institute of Medicine, Crossing the Quality Chasm, 2001
Some of Our Groundbreaking Initiatives…

- 100,000 and 5 Million Lives Campaigns
- IHI Open School for Health Professions
- The IHI Triple Aim
- The Improvement Map & Passport
- STAAR (STate Action on Avoidable Rehospitalizations)
- TCAB (Transforming Care at the Bedside)
- Safer Patients Initiative (UK)
- Ko Awatea
- Scottish Patient Safety Programme
- Chronic Care Initiative (Indian Health Service)
- WIHI
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in an improvement?

Act
Plan
Study
Do

PDSA

Associates in Process Improvement
Definition of Harm

World Health Organization (WHO) Collaborating Centers for International Drug Monitoring defines an adverse drug event as follows:

“Noxious and unintended and occurs at doses used in man for prophylaxis, diagnosis, therapy, or modification of physiologic functions.”

• The IHI Trigger Tool methodology includes these PLUS any Noxious or unintended event occurring in association with medical care.
Eliminating Harm/Defects

- **Eliminate**
  - Eliminate the opportunity for error
  - Make it hard to do the wrong thing
  - Make it easy to do the right thing
  - Make errors visible
  - Minimize consequences of errors
  - Policies, Training, Inspection

- **Facilitate**
  - Standardization & Simplification

- **Mitigate**
  - Human Factors

- **Weak**

- **Strong**
Juran Trilogy
Two patient care units are working on reducing patient pressure ulcers on their units.

Unit A has reduced their rate by 60%, Unit B by 12%.

You ask the staff on Unit B about their work, and they say, “Our patients are different”.
We understand the importance of interactions of people.
We look for assumptions and beliefs that are behind decisions and actions we take.
We will rely more on intrinsic motivation and less on extrinsic motivation.
We appreciate differences in people and the importance of attribution error.
We understand that we have bad systems, not bad people.
Three Necessary Ingredients for Improvement

- **Building Will**
  - Motivating health care provider organizations to think beyond the status quo and imagine a better system

- **Harvesting Ideas**
  - Finding, cultivating, or inventing new approaches for better patient care

- **Getting Results**
  - Providing the support, methods and tools for teams to take action
“Benchmarking studies are perishable and time sensitive. What is a standard of excellence today may be the expected performance of tomorrow. Improvement is a continuous process, and benchmarking should be considered as a part of that process. As a result, although different authors have defined benchmarking in different ways, all these definitions have a common theme, namely: the continuous measurement and improvement of an organization's performance against the best in the industry to obtain information about new working methods or practices in other organizations.” (Kozak, 2004).

http://www.fmshk.org/database/articles/06mbdrflkay.pdf
You can benchmark against the average: there are those who perform better and those who perform worse than the average.
Or, you can benchmark against the best
NH Scotland HSMR; Jan 2008 – June 2012

11.4% reduction

7521 less than expected deaths
Serious Safety Events per 10,000 Adj. Patient Days
Rolling 12-Month Average

80% Reduction

** The narrowing thresholds in FY2005-FY2007 reflect increasing census. Adjusted patient days for FY07 were 27% higher than for FY05.

Chart Updated Through 31Aug09 by Art Wheeler, Legal Dept.

Source: Legal Dept.
# Hospital-Acquired Events per 1000 Patient Days

AHS | Jan-09 - Dec-11
N=17295 Patient Records Reviewed

System Mean = 84.539
# Hospital-Acquired Events per 100 Admissions

N=17295 Patient Records Reviewed

System Mean = 37.543
% of Patients with Hospital-Acquired Events

System Mean = 25.923

N=17295 Patient Records Reviewed
# of Hospital-Acquired F+ Events per 1000 Patient Days

System Mean = 37.797

N=17295 Patient Records Reviewed
Ventilator Associated Pneumonia Rate
(per thousand ventilator days)

61% reduction

9.11 -> 3.54
Central Line Bundle Compliance

9.5% improvement

96.5%
Central Line Infection Rate
(per thousand line days)

2.8

70% reduction

0.84
Næstved Sygehus

MASP1 - Procent korrekt udfoerte basisobservationer

Month

average_team
Sepsis Reduction

Sepsisindlæggelser på ITA, Næstved

Median = 7
Obs. (useful) = 29 (24)

New median = 4
Crossings (min) = 7 (8)

Longest run (max) = 12 (8)
Days Between

Dage siden sidste VAP 421

Længste periode uden cvk 638
Best Care
Always

Strategic Guidance and Operations

Campaign Leadership Team

Corporate Delivery Team (HMC and IHI)

Campaign Operations Team (HMC and IHI)

Building Improvement Capability

IHI IAs and Fellows (1-5 staff)

HMC Local Fellowship Program (12 – 36 staff)

IHI Foundations Training Program (~500 staff)

The IHI Open School (All HMC staff)

Qatar National Health Strategy

HMC Academic Health System

Knowledge from the field: Success and Challenges

Defining Needs, Managing Operations

The Hamad Medical Corporation Campaign

Collaborative Work streams

Fellows and Local Fellows

Multidisciplinary Improvement Teams

Program Managers

Campaign Ops Director

Local Improvement

Day-to-day leadership

Campaign Leadership Team

IT

Human Resources
What We Plan to Accomplish

- Reduce harm
- Focus will be in prototype areas
- Specific harms will be reduced
- Time line: 1 year for pilot units
Aim

- 50% improvement in measures associated with the set change packages in the participating teams by September 2014
- 50% improvement in measures associated with the set change packages across HMC by September 2015
How Will We Know

- **Measures**
  - Process and Outcome measures per change package

- **Participating Teams**
  - Year 1: prototyping with 40 teams
  - Teams from Perioperative area, Med/Surg, General Ward, Intensive Care

- Year 2: Spread
HMC’s Best Care Always Collaborative

Work-stream

- General Ward Med/Surg:
  - VTE
  - CAUTI, MRSA, CDiff, Sepsis
  - Pressure Ulcers

- Critical Care:
  - VTE
  - CLBSI
  - CAUTI, MRSA, CDiff, Sepsis
  - Ventilator Acquired Pneumonia

- Peri-operative Care:
  - VTE
  - Surgical Safety Checklist
  - Surgical Site Infections

Change Packages With Tested Changes
Our Journey Begins Today

- Know where you are
  - Baseline Process and Outcome measures

- Know where we want to go
  - Best Care Always, Safest Care First

- Know how to get there
  - Change Packages
  - Use an improvement method

- Know when we arrive
  - Measures