

ON THE CUSP: STOP BSI NEWSLETTER

July/August 2010

Tennessee Leads the Way in Transparency

The Tennessee Hospital Association (THA) is exhibiting strong leadership in its mission to eliminate central line-associated bloodstream infections (CLABSI). The hospital association has taken a direct and transparent approach in communicating to hospitals and other health care stakeholders in its state that action must be taken immediately to eliminate preventable harm.

"We've tried to put a human face on the problem," said THA President Craig A. Becker. "We decided to make zero our goal. The *Stop BSI* project goes to the core of THA's mission in that hospitals want to provide the best possible care for all patients in Tennessee."

THA's review of the 2008 rates of central line infections and other health care-associated infections (HAIs) in its state was a turning point for the association. "We were appalled at the numbers," Becker said. "THA responded boldly to the statistics, showing hospital CEOs the true impact by focusing on the number of patients harmed, not just rates, and putting a face on harm by having Sorrell King address the hospital leaders and share Josie's story."

A Tennessee state law was passed in June 2006 that requires all hospitals in the state to report certain types of HAIs – including CLABSI – to the Tennessee Department of Health through the CDC National Healthcare Safety Network (NHSN). Data on CLABSI and numbers of central line days have been collected for all Tennessee ICUs since January 2008 and, in December 2009,

the Tennessee Department of Health issued a report on 2008 infection rates.

In response to the report, the THA board of directors' taskforce on quality and patient safety recommended aggressive goals for reducing preventable harm on three fronts: CLABSI, hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) and surgical care improvement project (SCIP) strategies. Specifically, the goals are: reduce CLABSI and hospital-onset MRSA rates to zero within three years, and achieve 95 percent compliance with Centers for Medicare and Medicaid Services (CMS) core measures on surgical care quality. Incremental targets for CLABSI are a 50 percent reduction in patient harm within one year and a 75 percent reduction within two years.

The THA board recognizes the importance of CEO accountability and in March of this year issued a memo to all hospital CEOs in the state with recommendations for action. The memo communicated the THA



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board's aim of "zero preventable harm" and urged CEOs to:

- Commit to making changes in their own organizations to achieve a rate of zero preventable harm.
- Communicate the aim of zero preventable harm to all within their organizations.
- Take personal responsibility/accountability for meeting the aim.
- Achieve a culture of safety where staff are encouraged and supported to learn from errors.
- Be available to share best practices to expedite learning.
- Devote 25 percent of hospital board meetings to quality and safety.
- Add performance data for key targets (CLABSI, MRSA and SCIP) to organization scorecards, leadership and trustee reports, and provide regular feedback to all staff.
- Report patients harmed, not just rates/benchmarks.
- Commit time and resources to support needed system changes.

Becker knows the importance of engaging physicians, and another approach Tennessee has taken is to convene a chief medical officer (CMO) society. The Tennessee CMO society was modeled on a similar group convened by Texas Hospital Association President Dan Stultz. "The CMO society started as a networking group," Becker said, "and soon the participating CMOs took ownership and started driving patient safety in their hospitals."

Since mandatory HAI reporting began in January 2008, two health systems have already made great strides in reducing CLABSI. One health system improved its CLABSI rates by 57 percent from 2008 to 2009, and another improved its rates by 45 percent in the same period. The overall averages have not improved as much or as quickly as they would have liked, but they have made incremental progress.

- The average number of central line days between CLABSI cases by hospitals improved significantly from 751 in 2008 to 924 in 2009.

- 63.4 percent of hospitals (26 of 41) that could be assessed for improvement in 2009, based on their 2008 performance, showed improvement.
- CLABSIs in 21 NICUs partnered with the center showed a statistically significant 50 percent reduction in the standardized infection ratio (SIR) for the 25 months analyzed, January 2008 through January 2010.

Becker and THA colleagues like Darlene Swart, vice president and project director of THA's Tennessee Center for Patient Safety (TCPS), have been vocal proponents of *On the CUSP: Stop BSI* since its inception. Swart stated, "Like many other states, our hospitals previously had worked on CLABSIs, but *On the CUSP: Stop BSI* has helped them focus on safety culture and not just the technical work. It also has emphasized the need for unit-based frontline teams, active senior leadership involvement, and the need for medical staff champions and shared accountability among all staff."

According to Becker, the association has used an aggressive approach in the past and tried to get all hospitals on board all at once. More recently, THA started using innovative ways of engaging hospitals through more carefully targeted approaches. One way it has done this is to convene hospitals and encourage them to share their challenges and lessons learned. Hospitals share stories about areas in which they encounter barriers, what they learned, and their processes for improving outcomes. The TCPS has engaged hospitals across the state through monthly conference calls, regional networking meetings and statewide conferences.

Becker, Swart, and THA are national leaders in their mission to reduce bloodstream infections, and they provide a courageous model of head-on efforts to reduce infections to zero. By putting a human face on the problem, they are helping hospital leadership turn patient safety into a top priority.

For information on reducing health care-associated infections in Tennessee, please see www.tnpatient-safety.com or contact Darlene Swart, dswart@tha.com.

AHRQ Approves Funding for State Leaders

In acknowledging the central role of hospital associations and their state coalitions in coordinating *On the CUSP: Stop BSI* in their states or territories, AHRQ recently authorized \$5.8 million in funding for part-time staffing and special needs at the state level. Both currently participating and new states are eligible to apply for up to \$70,000 over their two-year participation period to cover part-time staffing needs, as well as supplemental funding to support the

project. To obtain these funds, each state will need to complete an application, sign a consulting agreement, and meet certain compliance metrics pertaining to project participation. Currently participating states should contact Marchelle Djordjevic with any questions at 312-422-2614 or mdjordjevic@aha.org. New states slated to begin in the fall should contact Deborah Bohr with any questions at 646-678-4280 or dbohr@aha.org.

A Word from John Combes



There is terrific work being done in states across the country toward eliminating central line-associated bloodstream infections (CLABSI) and other health care-associated infections. *On the CUSP: Stop BSI* represents a continuing opportunity to collect robust, current data that will exhibit progress to policymakers and the public over the coming months. The Centers for Disease Control report of National Healthcare Safety Network data released on May 27 shows promising results of efforts to reduce CLABSI, and the *On the CUSP: Stop BSI* project team anticipates that these trends will continue. On behalf of the national project team I'd like to thank each of the state leads and their hospital teams in doing the hard work of improving safety culture and committing to eliminating infections. We're already seeing progress. Let's continue to work together to get to zero.

CDC Releases State-Specific CLABSI Report

The Centers for Disease Control and Prevention released on May 27 the First State-Specific Healthcare-Associated Infections Summary Data Report. The report is the first instance of CDC reporting state-specific infection information and includes both state-specific and national statistics. State level data were gathered through the National Healthcare Safety Network (NHSN). "The results of the report are encouraging," said Don Wright, MD, Deputy Assistant Secretary for Healthcare Quality with the U.S. Department of Health and Human Services. Report findings indicate an 18 percent decrease in central line-associated bloodstream infections. The report will serve as a baseline in gauging the impact

of state level efforts, including involvement in the *On the CUSP: Stop BSI* initiative. For more information on the report, visit <http://www.cdc.gov/hai/statesummary.html>.



"Central line-associated bloodstream infections are the polio campaign for the 21st century. Working together... we can substantially reduce these infections."

—Peter Pronovost