Chasing Zero…

Beyond Benchmarks

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The Sixth National Pay for Performance Summit

March 24, 2011

Hyatt Regency San Francisco

San Francisco, CA

Agenda

- **Background**
  - HMSA & Hospital PFP & QIAs
  - BCBS Association & Patient Safety Initiatives
  - The Ecology of the Hospital Community
  - Drs. Lin & Peter Pronovost
  - Impact on HMSA Leadership
- **The Hawaii CLABSI Experience**
  - The Challenges
  - National Initiative & HMSA
  - “Ohana means “nobody gets left behind”
  - Results
  - Discussion

Background

- HMSA & Hospital PFP & QIAs
  - HQSR – 2001
  - Low Profile of QI in Hospitals
  - HQSR – Emphasis on QIAs
- BCBS Association & Patient Safety Initiatives
- The Ecology of the Hospital Community
  - Little Community Collaboration in QI
- Drs. Lin & Peter Pronovost
  - Confluence of QI & Cost of "Waste"
- Impact on HMSA Leadership
  - "Why isn't this being done in every hospital?"
  - Funding & C0mmitment

The Hawaii CLABSI Experience

The Challenges: Lack of Infrastructure, Leadership, Collaboration

- **Hawaii has no mandatory reporting of HAIs**
- **The will was there, but no timely infrastructure for execution:**
  - **Hospital Association in leadership transition**
  - **Hospitals with budget constraints**
  - **"We are already doing this"**
  - **"We are different"**
    - **Rural**
    - **Academic**
    - **System**
    - **"sicker patients"**
- **Lack of previous collaboration – level of trust in early formative stages**

The Hawaii CLABSI Experience

More Challenges

- **Our baseline median rate was zero**
  - **Numerator was not zero**
  - **Inevitable to preventable**
- **Many hospitals already doing QI on CLABSI**
  - **But they were not approaching QI it this way**
  - **It takes THREE!**
    - **Reliable evidence-based practice**
    - **Culture**
    - **Data… prompt data**
- **Bottom line…**

….we were still harming patients

The Hawaii CLABSI Experience

National Initiative & HMSA

- If it can be done in Michigan, why not elsewhere?
- A structure without "structure"
  - Private Grant opportunity
    - Agreements without vast paperwork
    - Memorandums of understanding
    - Data Use Agreements
- What HMSA provided
  - 0.1 FTE physician lead, 0.25 FTE staff assistant
  - Face: Face logistics
    - Neighbor island support
- What we asked for from the hospitals:
  - Team
  - Data
  - Statewide learning

The Hawaii CLABSI Experience

"Ohana means "nobody gets left behind"

100% participation:

- **Hospitals in and outside of HMSA network**
- **First true representation of statewide data**

Learning Collaborative:

- **Interdisciplinary teams**
  - Original Cohort:
    - » 21 Adult ICUs
    - » 1 PICU
    - » 3 ED/Ors
    - » 4 Med/Surg
  - Pre-immersion calls, National Immersion Calls (8), Content calls (1/month), Coaching calls (1/month), twice yearly face: face meetings
  - Weekly updates/tools, Web page , Tailored on-site visits, availability for coaching

HMSA

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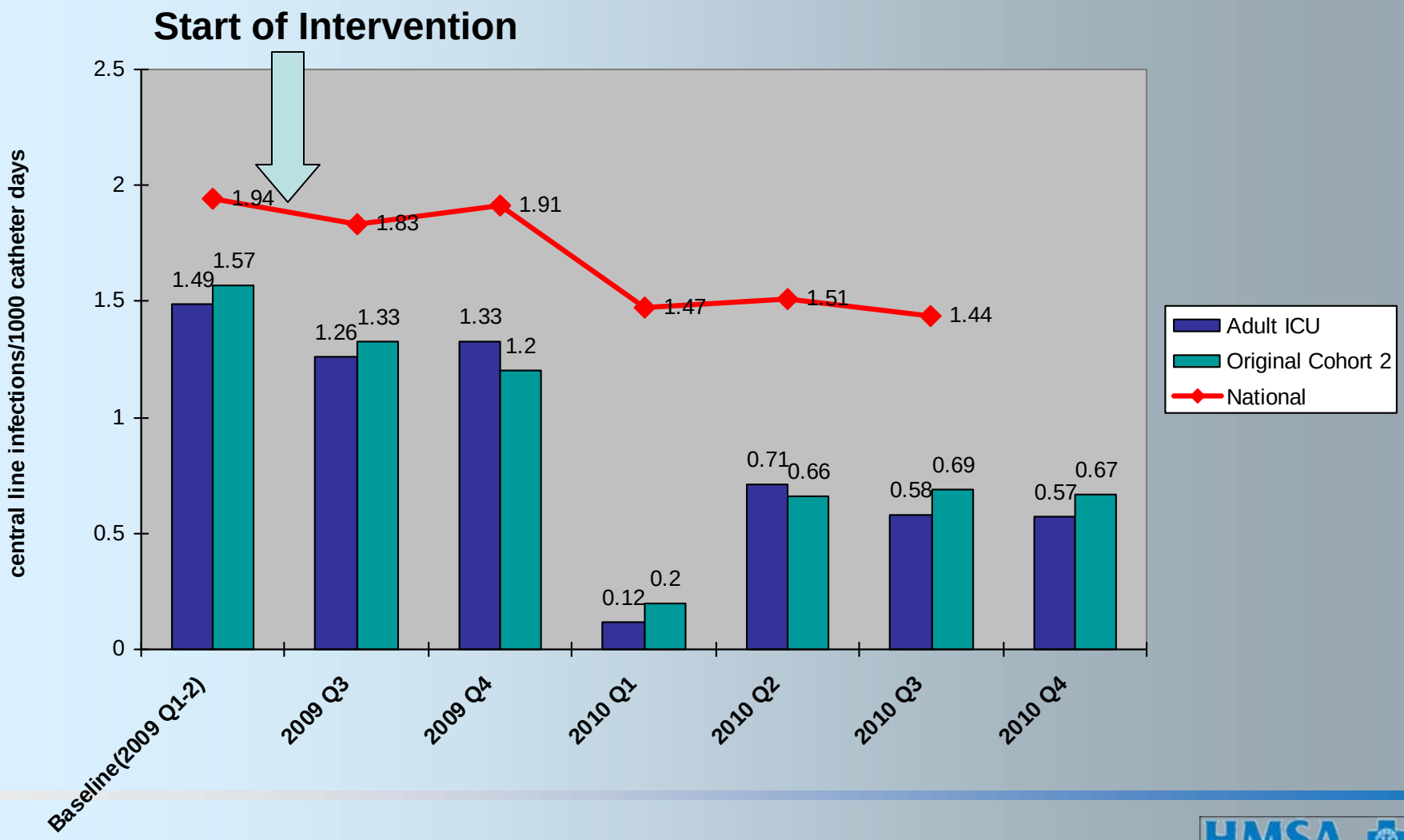
From 2009 to 2010, the central line infection rate has dropped over 60% from an annual rate of 1.41 to 0.55 infections/1000 catheter days



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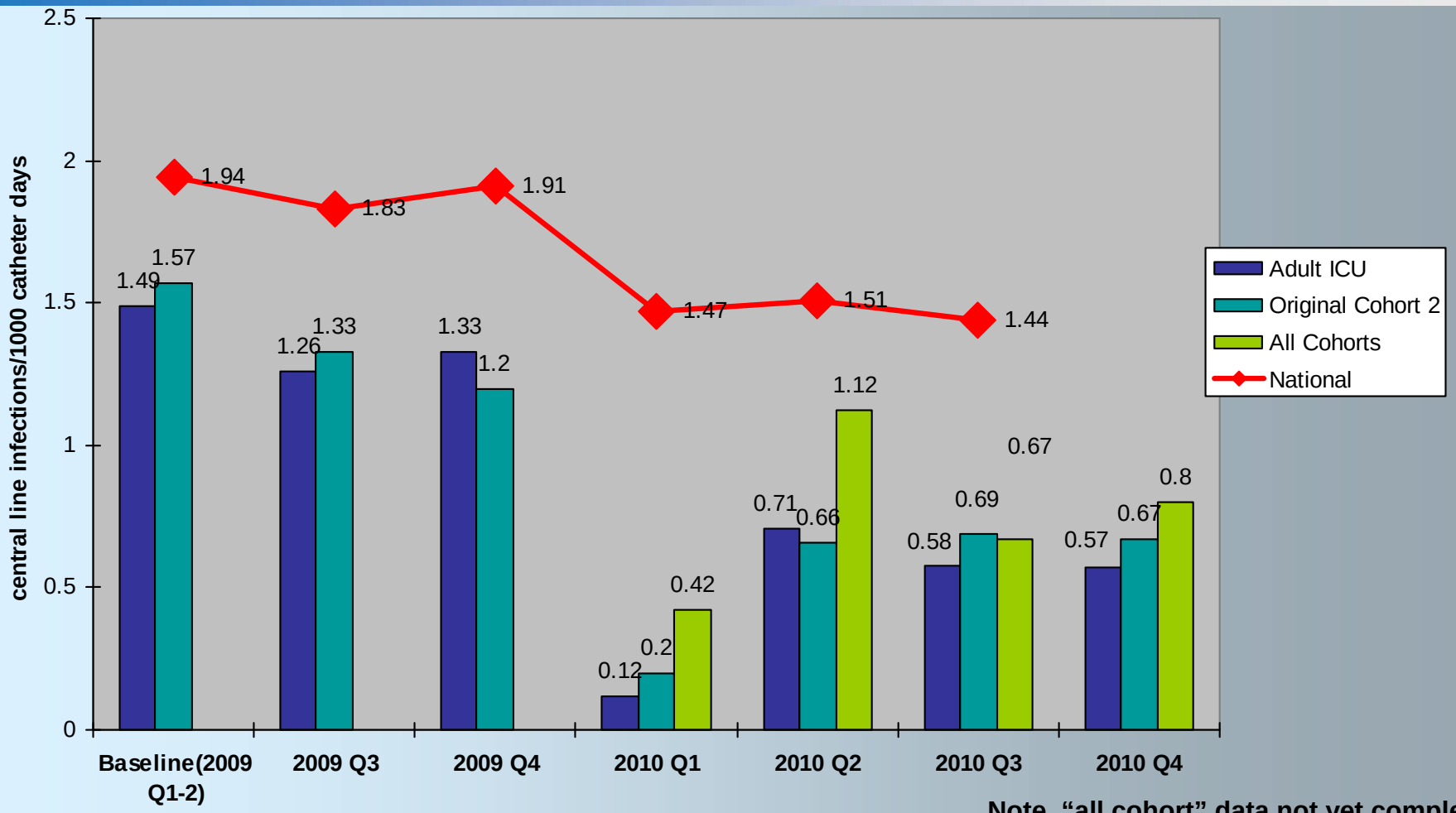
Beginning a ripple effect: Add teams



Note, "all cohort" data not yet complete

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Discussion

- **Ripple Effect:**
  - Culture of teams for sustainability
  - From shielding cases to sharing cases… yes, trust
  - Statewide CMO network
- **From Disconnected to Connected:**
  - Not just about checklists
  - Quality and culture are interdependent
  - Prompt, accurate data feedback is essential
  - Connect with C-Suite, payor
  - Accountability that connects with larger aims
- **Consider P4P/ Collaborative structures with flexibility**… this too, is a system that can be designed to achieve the results it gets
- **The journey is constant**… don't be anchored to benchmarks