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President's Report by Tom Evans, MD

It's amazing what a state can do if it puts its mind to it.

With mounting national focus in the area of hospital-associated infection, many states have passed legislation forcing hospitals and providers to publicly report infection data. While all agree that transparency is critical to performance improvement, this approach is fraught with the challenges. For many hospitals, the additional cost and administrative burden of reporting in this highly complex area has been prohibitive. In addition, until recently national definitions and methodologies for reporting specific infection information has been lacking. As a result, it has been difficult to do truly comparative reporting of hospital performance in this area.

In 2006, the Board of the Iowa Healthcare Collaborative challenged the Iowa healthcare community to focus on healthcare associated infection. Because each hospital builds an infection rate based on individual measures they select, truly comparative reporting across a common set of infections wasn't possible. IHC brought Infectious Disease specialists and

infection control professionals from across the state together to select a measure set from standardized national definitions. In 2007, Iowa hospitals were asked to begin voluntarily reporting performance for the initial six measure set to IHC. IHC then published this information in the Iowa Report as a statewide aggregated average and range. Though a voluntary program, participation has been excellent with over 90% of hospitals reporting in most categories. Over time, the original measure set has been expanded to eight measures. Finally, as we've refined methodology, the reporting model will move from a statewide aggregated reporting to hospital-specific reporting for all measures later this year.

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IHC also challenged the hospitals of the state to focus on influenza vaccination of healthcare workers in 2006. The CDC has promoted this issue as critical public health for over a decade. At that time, national rates of healthcare worker influenza immunization were in the range of 35-42%. Since then, concern about potential epidemics from the Bird Flu and H1N1 have focused national consumer attention on the issue and underscored the importance of this project. As a nation, we've made limited progress on this issue.

With this in mind, IHC challenged Iowa hospitals to have 95% of hospital employees immunized for influenza by 2010. At this point, we didn't even know what the rate was for Iowa, but it seemed like the right thing to do. "Employees" were broadly defined...not just those delivering patient care, but "if you get a paycheck, get immunized." Hospitals were asked to collect information on eligible employees (received a paycheck between October 1 and March 31) as a denominator, and to track those immunized as the numerator. Hospitals also gathered data on those allergic to the vaccine and those immunized outside of the facility.

In the first season (2006-2007), the Iowa rate was 68%, well above the national average, but well below our goal. In the second season we realized a statistically significant improvement to 76%. This generated a lot of enthusiasm as it appeared our goal might be in reach. Last year, however, progress appeared to stall. The rate in 2008-2009 improved only 3% to 79%. This prompted a lot of discussion in the community about hospital policies for immunization, and intensified the efforts of hospitals across the state.

I'm proud to report that in the 2009-2010 immunization season, 91% of Iowa hospitals workers received the vaccination. While not reaching our goal of 95%, this milestone is cause for celebration. This compares very favorably with the latest estimate of national performance at 62%. What's more, others are following our example. Kansas has started the Kansas Healthcare Collaborative and is running a similar program. Dr. Chuck Helms, our past board chair and an infectious disease specialist at the University of Iowa has given several presentations on this program nationally and internationally. Finally, we've been contacted by the CDC to find out "just how we did that". We've got more work to do.

I want to give a special thanks to the infection control professionals across the state. Without their leadership, we wouldn't have gotten this far. I also want to thank our Healthcare-associated Infection Work Group, who first proposed this idea in 2006. Their courage to propose that we try to get the whole state to do the right thing was truly visionary and courageous.

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CDI and CAUTI Subgroups Meeting on Iowa Reduction Strategies

Two subgroups have been appointed by the Iowa Department of Public Health to review strategies to reduce clostridium difficile (CDI) and catheter-associated urinary tract infections (CAUTI). These two infections are the primary targets of the Department's program aimed at reducing healthcare-associated infections in Iowa, funded through a special grant from the Centers for Disease Control and Prevention. Each subgroup, in their early June meetings, made the following recommendations:

- 1) CDI Subgroup endorsed a 30% reduction goal to be achieved within 2-5 years.
- 2) CAUTI Subgroup endorsed a 25% reduction goal to be achieved within 2-5 years.
- 3) Both subgroups recommended that CDC's recommended "Core" strategies be promoted as the focus of IDPH's HAI reduction for the hospitals participating in the project.

For CDI efforts, the following "core" reduction strategies were endorsed by the subgroup:

- 1) Use of contact precautions
- 2) Hand hygiene
- 3) Cleaning and disinfection of equipment and the environment
- 4) Laboratory-based alert system for immediate notification of positive test results
- 5) Education on CDI for healthcare workers, housekeeping staff, hospital administration, patients and families

For CAUTI reduction efforts, the subgroup endorsed the following "core" strategies:

- 1) Insert catheters only for appropriate indications
- 2) Leave catheters in place only as long as needed
- 3) Ensure that only properly training staff insert and maintain catheters
- 4) Insert catheters using aseptic technique
- 5) Maintain a closed drainage system
- 6) Maintain unobstructed urine flow
- 7) Hand hygiene and standard precautions

Both subgroups will meet again in late July/early August and will discuss CDC supplemental strategies for each infection and educational approaches for supporting hospital adoption of the various core strategies. A presentation on these recommended strategies is scheduled for the

IHC Annual Conference in Ames on September 1st. Gerd Clabaugh is the IHC contact for the project. He can be reached at clabaughg@ihconline.org. Barb Livingston is the State of Iowa HAI Project Manager and is with the Iowa Department of Public Health. She can be reached at blivings@idph.state.ia.us.

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Patient Safety Committee Develops Spread Dashboard

In its May meeting, the IHC Patient Safety Committee defined the layout and content for a Hospital Spread Report Dashboard. The dashboard, a private hospital-specific report, will be sent to hospital CEOs, CNEs and quality leaders semi-annually. The dashboard will show how hospitals compare to similar Iowa hospitals in deployment of quality and safety improvement initiatives.

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IHI Improvement Map Adds Three Processes

The Institute for Healthcare Improvement (IHI) has updated the 70 processes contained within the Improvement Map and has added three new processes to the map – Anticoagulation Management, Essential Care for Frail Older Patients, and Glycemic Control in Non-Critically Ill Patients - for a total of 73 improvement tools. The Improvement Map, an interactive, web-based tool designed to help hospitals with resources and best knowledge available on key improvement processes, is available to all healthcare providers at no charge. [ADD LINK TO IMPROVEMENT MAP](#)

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Cardiovascular Task Force Meets

The Cardiovascular Task Force met on June 9, 2010 at the Scheman Building in Ames. The purpose of the meeting was to review the implementation plan for the *Iowa Comprehensive Cardiovascular-Stroke Plan 2010-2014*, identify gaps in partner organizations to support the implementation strategies, and create a synergy with existing initiatives. The task force was joined by the Iowa Stroke Task Force and the Iowa STEMI Task Force. Velma Theisen, manager of the Michigan Heart Disease and Stroke Prevention Program, shared her experiences in implementing Michigan's heart disease and stroke strategic plan.

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Medical Home Learning Community Update

The spring Medical Home Learning Community presented timely information on the national movement toward medical home, the HITECH Act and IFMC Iowa HIT Regional Extension Center and the usefulness of lean applications in establishing medical homes.

Office practices participating in the Medical Home Learning Community can elect to participate in 2010 Summer Office Improvement projects to encourage patient-centered medical home principles and/or preparation toward “meaningful use” reporting initiatives. Working in a 60 day lean process cycle and with networking and facilitation support, clinical leaders in Iowa office practices will encourage office improvements in the following:

Access to Care:

- Smoking assessment for 13 years and older
- BMI assessment

Care Coordination

- Readmission/reduction coordination for Congestive Heart Failure patients
- Medication Reconciliation during transitions of care
- Reminders to patients for wellness and prevention

Access

- Timeliness of Response Time in Office Practice
- Triage Assessment and Management

It is anticipated that several offices will provide improvement reports at the fall September 22, 2010, Medical Home Learning Community seminar. MHLC Seminar topics will also pediatric medical homes, meaningful use, and lean improvement processes.

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Meaningful Use and the New Medical Home

A critically important piece of the current national health reform movement is the building of a national framework for the use of healthcare information technology (HIT) as promulgated by the Healthcare Information Technology for Economic and Clinical Health Act (HITECH Act) within the American Recovery and Reinvestment Act (ARRA) of 2009. The planning for this important piece of healthcare infrastructure has been in development for at least 3 administrations, but it has been largely overlooked and underappreciated - until now. The groundwork has been laid, cornerstones are set in place, and key components of the foundation and framework for health reform are being nailed up. At the time of this writing, the Centers for Medicare & Medicaid Services (CMS) is nearing the release of a final rule that will set in motion long-term plans that aim to assist healthcare providers “meaningfully use” electronic tools in ways that address nationally prioritized areas for improvement. This “wiring” of our national infrastructure is connected to many other key structural components of our national “medical home” and is a long time in coming.

The Architectural Drawing:

Nearly a decade ago national healthcare expert members of the Strategic Framework Board

(SFB) convened by a White House planning committee recognized the need to develop a national system that delivers a single level of quality healthcare to all Americans, develops a single set of priorities to be disseminated and translated throughout local healthcare delivery systems, and develops an efficient national quality measurement and reporting system (NQMRS) to monitor and guide improvement activities ¹.

Groundwork and Cornerstones:

The past decade has produced a considerable amount of construction work on a national strategy to improve the healthcare NQMRS infrastructure. Today there exist a consensus-based list of national goals and priorities, over 600 scientifically evidence-based quality and safety measures endorsed by the National Quality Forum, public reporting of many important indicators of healthcare delivery performance, and electronic definitions and data standards for 42 of the 110 current measures identified for “rewiring” efforts have been completed.

Wiring the Framework

It’s now almost time to move into a substantially remodeled national “medical home”. The ARRA Act allocated approximately \$19 billion dollars to assist physicians and hospitals in adopting and “meaningfully using” the high-tech wiring in our home. As proposed by the HITECH rules healthcare providers will receive financial incentives to purchase, receive guidance, and use in meaningful ways that align with national priorities and goals, “qualified” interoperable electronic health record (EHR) modules. By design interoperable computerized modules will facilitate the collection of raw data that is collected only once and nearest the source of care, accurate, complete, available in a timely manner, private/secure, and useful for a number of purposes ². The goal is that through the efficient and effective use of these technologies healthcare becomes safer, timely, efficient, effective, equitable and patient-centered.

Maintaining the Medical Home:

Healthcare is already an incredibly complex, and technical industry. Thus, introducing more complexity through the introduction of information technology will require that we stay the course over time and build a solid foundation for our national medical home. Over a period of 5-6 years, the HITECH Act phases in the “wiring” and “meaningful use” construction of our medical home. The costs of financing construction and training will be relatively high. And, it is a given that remodeling projects will need to be undertaken as has always been the case in healthcare. Over time we will need to rip out walls and rewire existing infrastructure; wire new additions to our home; and train both providers, patients, and patients’ families how to “meaningfully use” the features of our home.

A Strategic Framework Board member prophetically stated in 2003 “making changes will require new investments. We expect that, over the long run, from a societal point of view, those investments will more than pay for themselves, but the payback period will not be immediate and an initial investment will be required. Nonetheless, we all stand to benefit from taking the steps necessary to make the American health care system the best it can be” ¹.

Initially; it will be neither cheap, nor easy, to introduce new wiring in existing healthcare

delivery infrastructure. We can't build new medical homes from the ground up. And, the current landlords of our medical home will need to be convinced of the business case for upgraded wiring. But, the status quo is not tenable. We have spent more per capita on healthcare than any other industrialized country, and for many indicators of health performance our outcomes are worse. The HITECH Act "meaningful use" blueprints represent a unique and historical opportunity to bring a reliable source of electricity to our communities, light up areas of opportunities for improvement, make our medical home more efficient and effective, and eventually improve our quality of life.

Lance Roberts – Data Coordinator, Iowa Healthcare Collaborative

1. McGlynn EA. Introduction and Overview of the Conceptual Framework for a National Quality Measurement and Reporting System. *Med Care*. 2003;41(1)(Supplement):I1 - I7
2. James B. Information System Concepts for Quality Measurement. *Med Care*. 2003;41(1 Supplement):I71-I79.

Plan to Join Us for the September 1, 2010 Annual Conference

IHC 7th Annual Conference on Quality, Patient Safety and Value will be held Wednesday September 1, 2010 in Ames.

Healthcare Reform is a "transforming" change. Please join us to learn how you can be part of the leaders to that change.

This year's conference will take the theme of transformation to the next level – Leading Transformation. We offer two preconference sessions. Based on feedback from previous attendees we will provide those who are new, or to those who would like a refresher to Lean and Medical Home introduction sessions.

David Nash, a dynamic national speaker, will set the tone for the day addressing the question "how will we face the challenge on new levels of transparency and public reporting".

Tracks will include **Leadership, Lean, and Performance Improvement.**

Bottom line – Healthcare is undergoing transformation, let us help you become a leader to that transformation.

Physicians, CEOs, CFOs, senior administrators, nurses, quality assurance professionals, trustees/board members, clinic managers, infection control professionals, hospital pharmacy directors, clinical pharmacists and other health care personnel should consider attending.

For complete details and registration forms [please click here!](#)

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