

Achieving Goals Through National Implementation of CUSP for CLABSI On the CUSP Stop BSI

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Eliminating or Mitigating CLASI Requires More than Measurement

A pig never gained weight by just standing on a scale



Actual Changes in Clinical Practice are Required

- A focus on practice at the unit level
- Not just a problem of the Infection Control Profession
- Engagement of all frontline professionals
- Requires a change in culture too

Change \ Intervention Program

- Comprehensive Unit-based Safety Program
- Developed at Johns Hopkins Medical Center in the ICU and other units
- Large scale test of CUSP \ CLABSI – Keystone Project in Michigan funded by AHRQ beginning in 2003

CUSP & CLABSI Interventions

CUSP

1. Educate on the science of safety
2. Identify defects
3. Assign executive to adopt unit
4. Learn from Defects
5. Implement teamwork & communication tools

CLABSI

1. Wash Hands Prior to Procedure
2. Use Maximal Barrier Precautions Clean
3. Skin with Chlorhexidine
4. Avoid Femoral Lines
5. Remove Unnecessary Lines

Building on Success

- Because the method works
 - › CLABSI rates in Michigan dropped to less than 1 per thousand and remained at this level for an extended period
 - › ARHQ believed progress in CLABSI rate reduction in other states was possible
 - › Launch the national implementation of CUSP for CLABSI
 - › On the CUSP Stop BSI.

On the CUSP - Stop BSI works

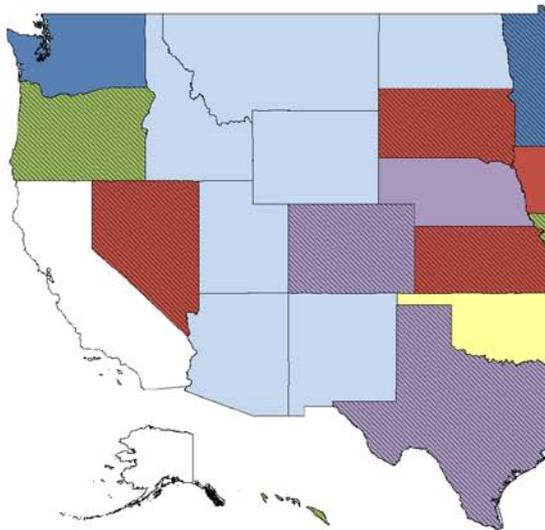
- Its goals:
 - Outcome Goals:
 - Reduce BSIs to 1 per 1,000 catheter days
 - Some states and hospitals view CLABSI elimination as the goal
 - Reach hospitals in all 50 states, the District and Puerto Rico
 - Include both ICUs and other units with BSI risks
 - Include Critical Access Hospitals
 - Improve safety culture

How On the CUSP: Stop BSI works

- Its leadership:
 - › Health Research & Educational Trust of the American Hospital Association (*John Combes, MD*)
 - › The Johns Hopkins University Quality & Safety Research Group (*Peter Pronovost, MD, PhD*)
 - › The Michigan Health & Hospital Association Keystone Center for Patient Safety & Quality (*Spencer Johnson/Sam Watson*)

Phased Approach by Cohort

State Participation in the On the Ground Project



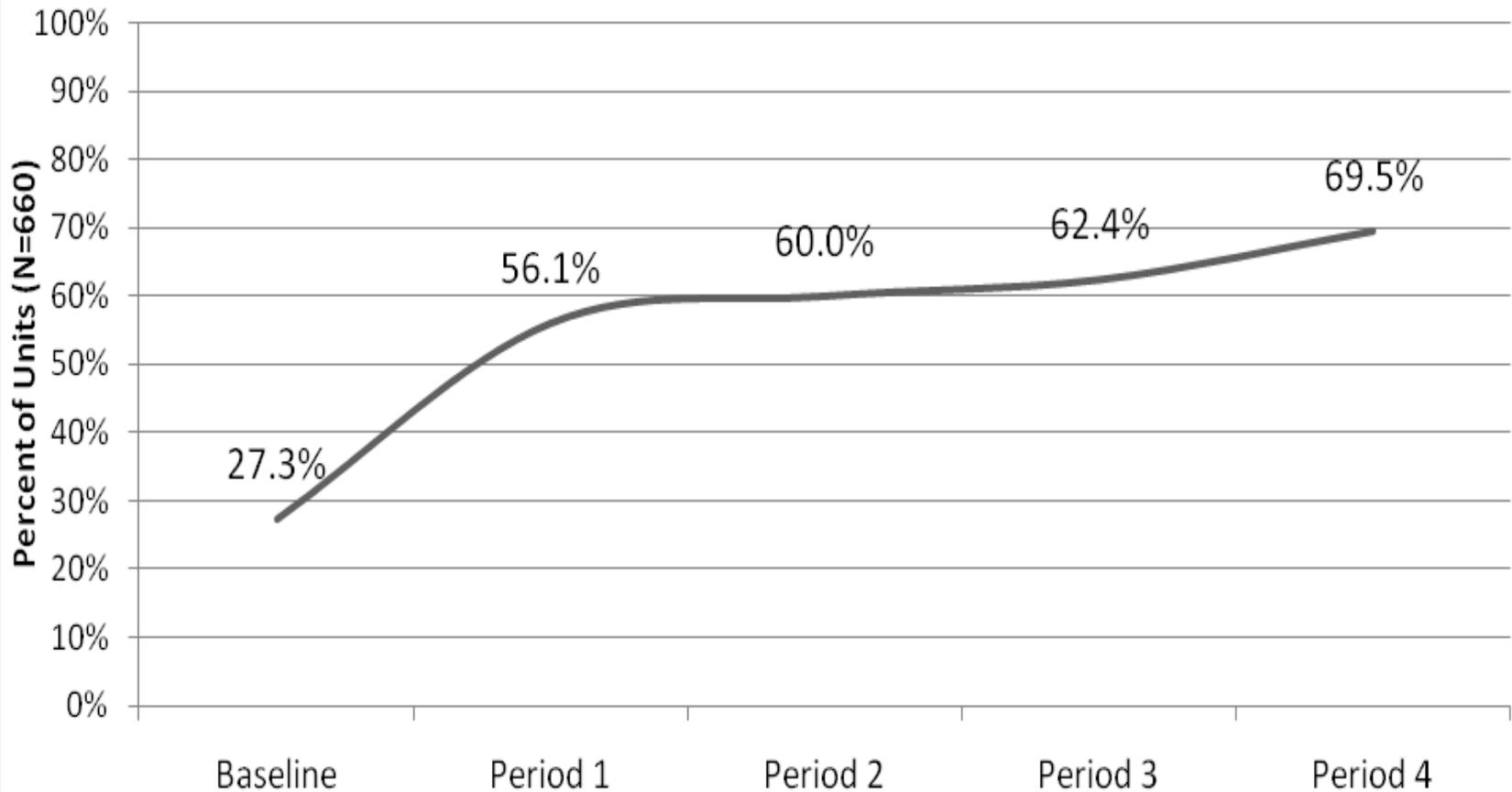
How are we doing

- 46 hospital associations and one umbrella group are participating
- 1,055 hospitals and 1,775 hospital teams to participate in the project
- Twenty-two States began the project in 2009
- 14 States, the District of Columbia began during 2010
- 9 States, and Puerto Rico began the effort in 2011

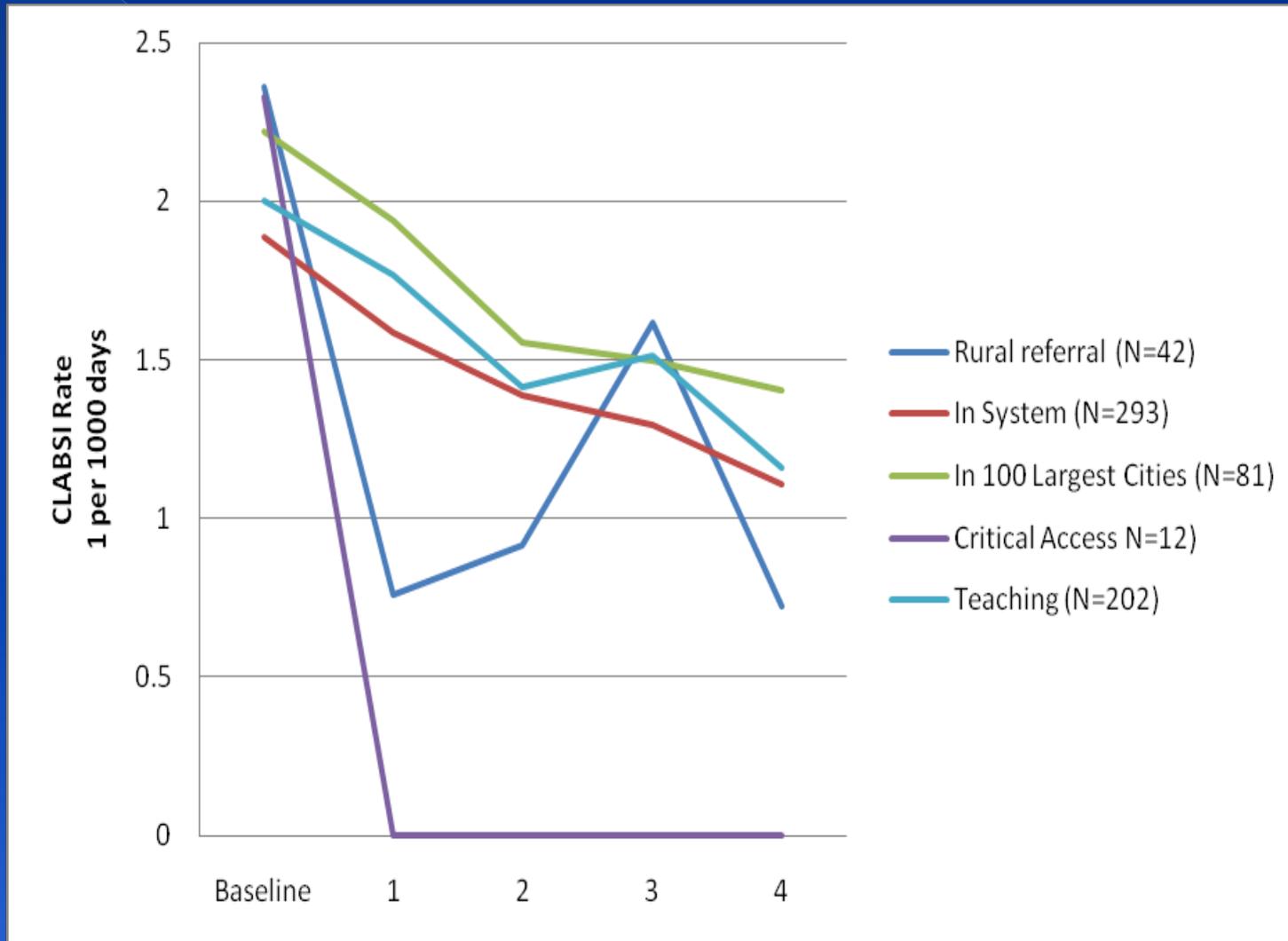
Results for State Cohorts 1 - 4

- Cohorts 1-4 starting in 2009 and 2010
- Baseline CLABSI rate of 1.87\1,000 central line days
- After 10–12 months rates have decreased to 1.25\1,000 line days
- Relative reduction of 33%
- The percentage of units with zero quarterly CLABSIs increased from 27.3% at baseline to 69.5% for cohorts 1 - 4 at the end of period 4

Getting to Zero



Hospital CLABSI Rates by Type



Expanding CUSP to Other HAIs and to other Hospital Associated Conditions (HACs)

- CAUTI
- VAP
- SSI and other surgical complication
- Perinatal Safety

CUSP for CAUTI

- Using the same state based structure we are expanding the CUSP activities to include CAUTI
- Just completed a pilot in ten States and ten hospitals in each state
- Nationwide expansion began yesterday 15 August 2011 On the CUSP Stop HAI
- Stay tuned recruiting begins NOW

CUSP for VAP

- A contract is being awarded to develop CAUP for VAP
- Three state pilot
- Nationwide implementation begins in FY 13

Surgical Unit Safety Program (SUSP)

- Focus on SSI as well as other surgical complications
- Builds on lessons learned with CUSP
- Incorporates WHO checklist
- TeamSTEPPS
- Safety Culture
- Sensemaking and learning from defects
- SUSP begins 1 September 2011

Perinatal Safety Improvement Project (PSIP)

- Birth injuries and obstetrical adverse events are one of the nine primary HACs that are part of the Partnership for Patients
- ARHQ is building on its evidence in L&D to initiate a Perinatal Safety Improvement Program (PSIP) in September 2011

PSIP

- PSIP include:
 - › Culture of Safety
 - › TeamSTEPPS
 - › In-Situ Simulation
 - › Checklists
 - › Sensemaking and learning from defects