



Introduction: The 100,000 Lives Campaign is a national effort to reduce hospital mortality by introducing up to 6 proven quality improvement strategies on a wide scale. In Oregon, 27 hospitals are working with the Institute for Healthcare Improvement and with the Patient Safety Commission to adapt these best practices to meet local needs and to implement them here. In order to learn more about how much progress is being made, the Commission surveyed Oregon participants in October and November, 2005.

Summary:

Of the 27 hospitals participating in the campaign, 21 are implementing all six of the recommended IHI strategies. The remaining six hospitals have decided to implement a subset of the six. Typically, hospitals choose this strategy because specific strategies (sometimes called ‘planks’) are not appropriate to their care setting (for example, they do not have patients on ventilators). In some cases, hospitals had already committed resources to other quality improvement activities.

About 1 in 3 rural hospitals are participating in the 100K Campaign. In some cases, smaller hospitals have been able to move faster than large hospitals/systems.

Some hospitals have raised questions about their ability to measure and document progress. Small hospitals have few cases; therefore, their numbers are subject to great variation. Some hospitals are struggling to sustain data collection efforts.

As their efforts are implemented and benefits seen, hospitals are finding ways to expand the initial interventions. For example, DVT (Deep Vein Thrombosis) protocols are being implemented beyond VAP patients; insulin protocols are being used for surgeries/patient populations other than the initial intended population.

With regard to extent of implementation, hospitals have made the most progress with surgical site infection protocols and with decreasing the numbers of VAPs (Ventilator-Acquired Pneumonia).

Hospitals are finding implementation of rapid response teams (RRT) and medication reconciliation (ADE – Adverse Drug Events) more problematic than other planks. However, hospitals are putting significant emphasis on ADE because of JCAHO’s the January 2006 deadline.

Lessons:

The participating hospitals have had similar experiences in implementation of the IHI planks and report several common lessons learned. The aspect of culture – hospital, unit, and health care professional is a key issue for all.

Start early and have patience in getting everyone on board with the plans and most importantly, the reasons behind the campaign.

Use an open process, and focus on the underlying patient safety values and evidence driving the changes.

Identify a champion to move the initiative along, especially with physicians.

Maintain reinforcement over 1-2 years until fully part of the culture.

Summary Data:

Below are tables and graphs summarizing the extent/level of implementation for each of the six planks in the IHI Campaign with comparisons of rural and nonrural hospitals.

Total number of hospitals currently participating in the IHI Campaign in Oregon: 27, including 2 VA, 11 rural hospitals

Planks and Levels* of Participation: (see below for graph of activities by plank)

Plank	Level				
	Unknown	Not Doing	Beginning Stages	Implementing	Routine Monitoring
ADE -Adverse Drug Events	2	1	17	6	1
AMI -Acute Myocardial Infarction	3	2	2	16	4
CLI -Central Line Infections	3	3	3	15	3
RRT -Rapid Response Teams	3	2	15	7	0
SSI -Surgical Site Infections	3	2	4	18	0
VAP -Ventilator Acquired Pneumonia	2	0	4	17	3

*Levels:

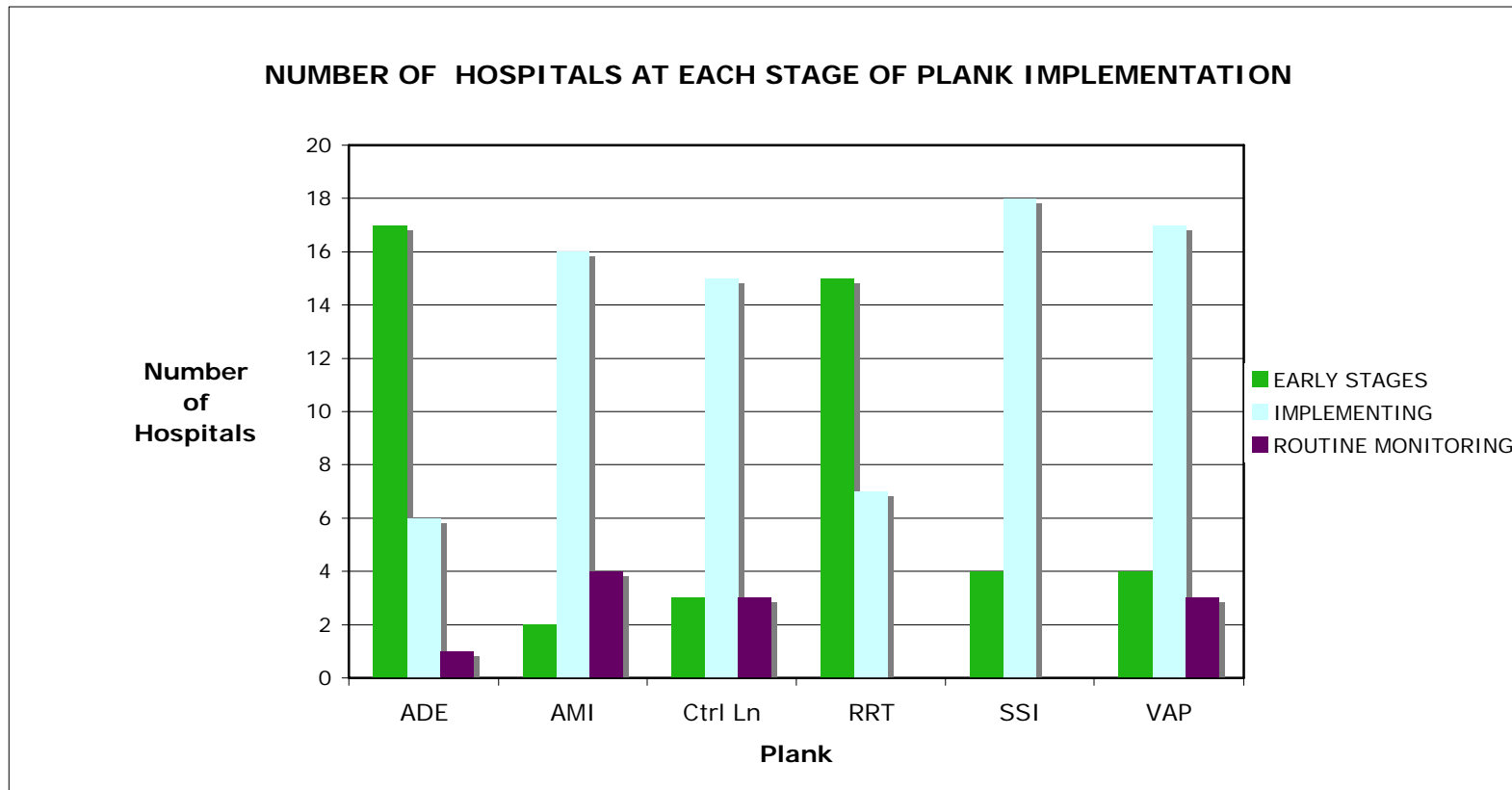
Unknown – no data available

Not Doing – no specific activities

Beginning Stages – Initial discussions/planning/pilots

Implementing – some/all parts of bundle in place

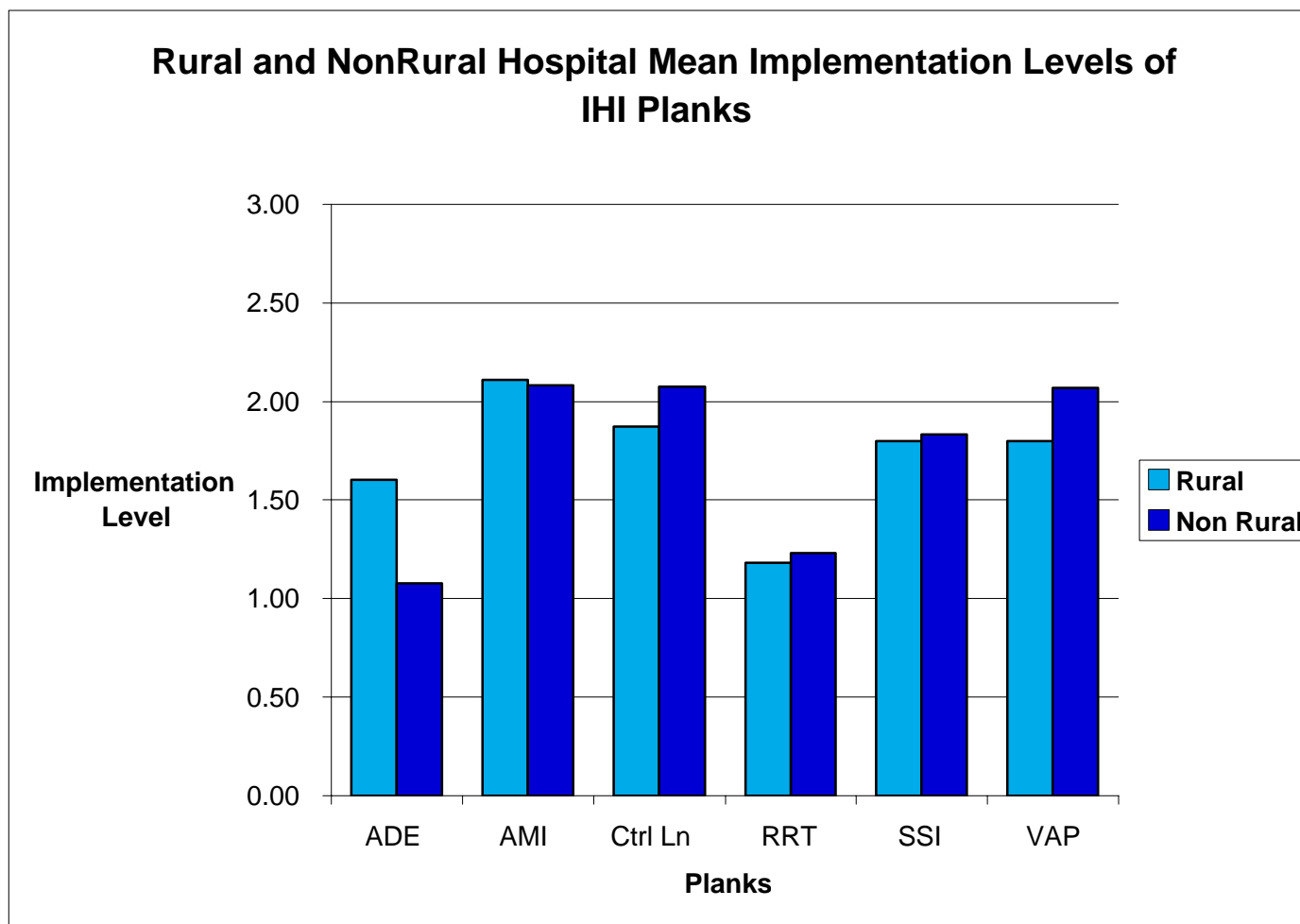
Routine Monitoring – all aspects in place, monitoring up and running



Description of Participating Rural Hospitals

Rural Hospitals	Participating	Not Participating	Total
	11	24	35
Type A - less than 50 beds, more than 30 miles from nearest hospital	2	10	12
Type B – more than 50 beds, 30 miles or less from nearest hospital	6 (includes 4 CAH)	14	20
Type C - 50 or more beds	3	0	3

Type of hospital based on Office of Rural Health definitions: <http://www.ohsu.edu/oregonruralhealth/rurhosp.html>



Plank	ADE	AMI	Ctrl Ln	RRT	SSI	VAP
Rural	1.60	2.11	1.88	1.18	1.80	1.80
Non Rural	1.08	2.08	2.08	1.23	1.83	2.07

The graphs on the following pages compare the stages of implementation for each of the IHI Planks in Rural and NonRural Hospitals.

