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

Agency for Healthcare Research and Quality

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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

<table>
<thead>
<tr>
<th>CUSP</th>
<th>CLABSI</th>
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<tr>
<td>1. Educate on the science of safety</td>
<td>1. Wash Hands Prior to Procedure</td>
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<td>2. Identify defects</td>
<td>2. Use Maximal Barrier Precautions Clean</td>
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<td>3. Assign executive to adopt unit</td>
<td>3. Skin with Chlorhexidine</td>
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<td>4. Learn from Defects</td>
<td>4. Avoid Femoral Lines</td>
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<td>5. Implement teamwork &amp; communication tools</td>
<td>5. Remove Unnecessary Lines</td>
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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 Project

U.S. Dept of Health & Human Services
Office of the Assistant Secretary for Health
Office of Healthcare Quality
www.hhs.gov/ash/initiatives/hai/
www.hhs.gov/ash/ohq/
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 CLABSI increased from 27.3% at baseline to 69.5% for cohorts 1-4 at the end of period 4
Getting to Zero

Percent of Units (N=660)

- Baseline: 27.3%
- Period 1: 56.1%
- Period 2: 60.0%
- Period 3: 62.4%
- Period 4: 69.5%
Expanding CUSP to Other HAIs and to other Hospital Associated Conditions (HACs)

- CAUTI
- VAP
- SSI and other surgical complications
- 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.
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
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