

The Institute for Healthcare Improvement 16th Annual National Forum on Quality Improvement in Health Care

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The Institute for Healthcare Improvement (IHI) 16th Annual National Forum on Quality Improvement in Health Care was held December 12–15, 2004 in Orlando, FL with more than 4,000 attendees, representing 28 countries, and reaching more than 6,000 additional participants via satellite in the United States, Canada, and the United Kingdom. The conference was also the meeting site for the 10th anniversary of the scientific forum, which supports the establishment of the scientific base for performance improvement.

The first IHI conference in 1989 drew only 287 attendees; thus there has been tremendous growth and interest in quality improvement (QI) over the past 15 years. The 4-day conference included a learning laboratory, mini-courses, and the full conference proceedings. Both plenary sessions and mini-plenary sessions were offered, as well as a vast array of topics. The main workshop themes included sessions on

- critical care
- flow in acute care
- innovation and spread
- leadership and governance
- measurement and tools
- office practices and outpatient setting
- patient centeredness
- patient safety
- workforce development.

Proceedings of the conference will be available on the Web at www.ihl.org at a later date.

In the opening session, Dr. Donald M. Berwick announced a new, first-ever national campaign, “Saving 100,000 Lives,” to be accomplished over the next 18 months (by June 14, 2006). The theme for the campaign is “Some is not a number. Soon is not a time.” The campaign to reduce mortality is based on the following six goals using evidenced-based practices:

1. Deploy rapid response teams
2. Deliver reliable evidence-based care for acute myocardial infarction

3. Prevent adverse drug events
4. Prevent central line-associated bloodstream infection
5. Prevent surgical site infection
6. Prevent ventilator-associated pneumonia.

Each of these six goals is based on research demonstrating a reduction in mortality. Goals 2, 4, 5, and 6 include “bundles” of several practices that should be considered together to achieve the maximum benefits, best outcomes, and reduced mortality. The idea of bundling several practices and measuring “composite” compliance rather than “component” compliance is an approach providing a different perspective of monitoring overall performance. In this approach, credit for compliance is given only when all components of the bundle are completed—an “all or none” attitude.

The original partners who appeared on a panel to endorse the campaign included the IHI, the American Medical Association, the American Nurses Association, Ascension Health, the Centers for Medicare and Medicaid Services, the Joint Commission on Accreditation of Healthcare Organizations, North Carolina State Hospital Association, SSM Health Care, and the Veterans Health Administration.

Organizations that joined the campaign later were The Leapfrog Group, the American Health Quality Association, Tenet, Hospital Corporation of America, Premier, Voluntary Hospitals of America, Inc., Dana Farber, and the National Patient Safety Foundation. By day two of the conference, more than 400 hospitals had joined the campaign, making progress toward the minimum goal of 1,600 hospitals needed to reach the desired goal of number of lives saved (The full campaign information can be found at www.ihl.org/IHI/Programs/Campaign/).

If the goals are to be accomplished, the campaign requires participation from hospitals staying the course with the message. The

conference sessions echoed the message of the campaign, that is, definite action now to improve care and reduce mortality. Sir John Oldham, MBA MCChB, described how to implement improvements in large complex systems by increasing access to primary care across the United Kingdom. This large system change was achieved through an IHI collaborative with four waves of implementation to increase access to primary care. The increase in capacity and access was achieved over 44 months with 11 spread centers affecting 32 million people. This process was achieved by transferring skills to a network of facilitators in the community and engaging people at the local level for improvement. Video clips highlighted community leaders applying the Plan-Do-Study-Act model to meet basic healthcare needs such as lighting and nutritious meals.

Sir Oldham presented four primary beliefs applied to this 4-year initiative, which he thought contributed to its success:

1. Push boundaries of what is currently done to create new solutions.
2. Be optimistic about overcoming obstacles—"A pessimist sees difficulty in every opportunity; an optimist sees opportunity in every difficulty," according to Winston Churchill. This belief requires overcoming mindsets, especially fear and anxiety.
3. Make a contribution—one must tap everyone's potential for change initiatives.
4. Take *calculated* risks. Not all risks are equal, so don't be reckless in taking risks.

Sir Oldham then described three stages of creating the environment for successful change: precontemplation, contemplation, and act on learning.

Engaging people, he said, is the key for successful change. This was evident in the miniplenary session on the spread of major change in the United Kingdom as well as in other large systems. Two large-scale changes in the United States were described by Jonathan Perlin, MD PhD MSHA FACP, acting undersecretary for health, U.S. Department of Veterans Affairs, VHA, and Sam Shekar, MD, assistant surgeon general and associate administrator for primary healthcare, Health Resources and Services Administration, Bureau of Primary Care. Both speakers described lessons learned from these two

national healthcare systems on increasing access and quality in primary care settings. The results clearly demonstrate improved performance in clinical measures, utilization, and cost reduction. The principles of advanced clinical access were applied in the VA presentation, illustrating how an evidence-based approach supports standardized care and improvement in health promotion and disease prevention.

Leadership through organizational transformation was the message of Sr. Mary Jean Ryan, FSM, president and CEO of SSM Health Care. As the first recipient of the Baldrige Award for Healthcare, SSM Health Care has many stories to share about its journey to excellence. As the president and CEO, Sr. Mary Jean Ryan described several views about her role in the process and the constant work of fulfilling the mission of the organization. After much work across 20 hospitals, SSM defined a mission that is only 13 words and easily embraced by every employee. This mission is also a personal philosophy of Sr. Mary Jean in her responsibility to foster the ministry and her moral obligation to provide the highest possible care all the time. Sr. Mary Jean further states it is her job to instigate, motivate, persevere, inspire, agitate, and never tire of explaining the mission. This perseverance never ends. In a society that demands instant gratification, hard work is not popular and perseverance is hard work.

The story of SSM Health Care's improvement journey includes three major aspects. The first is continuous QI integrated throughout the entire organization. Second is using the Baldrige framework to address all seven categories for excellence; and third is creating leadership at every level of the organization to implement the mission and resolve issues at the level closest to the work.

Although the earlier sessions focused on leadership, complex system change, and performance improvement, Uwe Reinhart, PhD, closed the conference by raising our consciousness on the cost dimension of quality. He challenged the participants to examine the value that is delivered for the cost. How do healthcare professionals determine the optimal point at which the highest quality healthcare is matched with the most reasonable cost? Reinhart further pointed out that as the proportion of GDP spent on healthcare continues to rise, there is an increasing reluctance to bear the burden to care for the poor and uninsured.

Table 1. Top Ten Improvement Ideas From 2004

Idea	Description	Resource
1. Purposeful creativity and innovation	Connecting and rearranging knowledge to develop new ideas	www.DirectedCreativity.com
2. Pattern mapping	Understanding patterns in organizational culture to make large-scale changes	www.modern.nhs.uk/pursuingperfection
3. Bundles to improve reliability	Groupings of evidence-based processes, which performed collectively as a “composite,” enhance outcomes	www.ihl.org/IHI/Topics/Improvement/Methods/ImprovementStories www.medqic.org/scip www.ihl.org/IHI/Topics/PatientSafety/SurgicalSiteInfections/ImprovementStories
4. Give control to patients	Making the patient the leader of a multidisciplinary team in making clinical decisions	Homan, H. (2004). Chronic disease. The need for a new clinical education. <i>JAMA: Journal of the American Medical Association</i> , 292, 1057-1059. IHI video series at www.ihl.org
5. Reconciliation at every handoff	Process of creating the most accurate list possible of all medications a patient is taking at every transfer point	www.ihl.org/IHI/Topics/PatientSafety/MedicationSystems/ImprovementStories www.jcaho.org/accredited+organizations/patient+safety/npsg.htm
6. Rapid response teams	Experienced team that is ready to respond to any provider wanting an opinion in a patient showing decline	www.ihl.org/IHI/Topics/Improvement/MoveYourDot/ImprovementStories/BuildingRapidResponseTeams.htm
7. Patient itineraries	Care paths that optimize sequence, distance and value-added time for patients	www.ihl.org/IHI/Topics/OfficePractice/SpecialtyCareAccess/
8. Bed turns and lean tools for flow	Number of times a bed is used by a patient	www.ihl.org/IHI/Topics/Flow/ www.lean.org/
9. Acuity adjustable rooms	Beds that can adapt to the patient's changing care needs	www.healthdesign.org Hendrich, A., et al. (2003). Effects of acuity adaptable rooms on flow of patients and delivery of care. <i>American Journal of Critical Care</i> , 12(6), 34–35.
10. Learning to see	Attention to change in patient status or needs based on safe systems	http://viscog.beckman.uiuc.edu/grafs/demos/15.html www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Resources/FMEA+Information+Centre.htm www.ihl.org/IHI/Programs/ConferencesAndTraining/PatientSafetyDevelopmentProgramMarch2005.htm

BRIEF REPORT

This focus on healthcare costs will continue to be a national issue for access and treatment across all populations.

The 2-day conference offered more than 75 different sessions addressing topics for acute care, ambulatory care, and office practice settings. Lessons from IHI collaboratives and projects such as “pursuing perfection” and “transforming care at the bedside” as well as “ventilator-acquired pneumonia” and “patient flow” were shared with participants. Current issues such as workforce shortages and national quality reports were discussed, and concepts such as “reliability” and “bundling” were explained. Patient safety as a key foundation for quality was discussed in several sessions including the panel presentation with Peter Pronovost, MD PhD, Sorrel King, patient advocate of the Josie King Foundation, Linda Kenney, founder and president of the Medically Induced Trauma Support Services,

Frederick A. van Pelt, MD MBA, director out-of-anesthesia, director, minimally invasive services, Brigham & Women’s Hospital, and Mark Rosenberg, MD MPP, executive director, the Task Force for Child Survival and Development. This panel brought home the critical point of personal involvement in healthcare and the importance of patient and family participation in all aspects of care. This particular panel presentation described three organizations’ responses to medical errors and the techniques to effectively communicate and respond to patients and families.

Although there were many take-home messages from the conference, the top ten improvement ideas from 2004 (see **Table 1**) provide ideas and tools for healthcare quality professionals.

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