"I’m losing my patience"

IHI CEO Dr. Don Berwick is creating a groundswell of support for healthcare improvement
Politics are a very strange animal. The vehemence brought to the table by the extreme left and right—and just about everyone in between, too—strikes me as both frightening and encouraging.

One on hand, the activism is heartening to see, especially in the youth. More people cast a ballot in 2004 than in any other Presidential election in the nation’s history, accounting for nearly 60% of eligible voters.

On the other hand, I read recently that while all of the ballots haven’t been counted yet, 50% or more of the eligible population voted in Iraq’s first election—and every single vote they cast was its own small victory.

American voters sometimes have to deal with long lines and confusing instructions; Iraqi voters had to keep an eye out for suicide bombers and black sedans distributing leaflets that promise death to every voter—not to mention the decapitation of their children.

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I understand the intensity to a certain extent—it was a polarizing film, for certain—but where is that energy when it comes to our healthcare system? Someone, somewhere, probably suffered an adverse health event while they were actually watching that film and had to go to the hospital. Did the concern and apprehension they felt while watching the movie escalate as they were en route to a healthcare facility? If not, perhaps it should have; experts agree that hospitals aren’t as safe as they could and should be.

My guess is, though, that their moral and political dander cooled after they left the theater, and that’s the first thing we should strive to change.

We need, as Dr. Berwick is showing, to harness that activism and motivation to change healthcare—not for some of us, but all of us—and we don’t need to do it soon, we need to do it today. MHE
A S GEORGE BERNARD SHAW once said, “Nothing is ever done in this world until men are prepared to kill one another if it is not done.” While accidental fatalities—even those caused by preventable mistakes and human errors—are a far cry from murder, Don Berwick, MD, has seen enough death. He’s also heard enough rhetoric about ways to improve healthcare quality.

“I’m losing my patience,” he said during his opening speech at the 2004 annual meeting of the Institute for Healthcare Improvement (IHI) in Orlando, “not with the people in healthcare, but the system itself. Healthcare professionals are doing so many things so well; they’re putting actual transformation within reach. Now we need to grab it. The clock is a tyrant, and if you spend too much time ‘getting ready,’ you’re going to lose.”

Dr. Berwick, founder of the Cambridge, Mass.-based IHI, has fought this battle on just about every possible front. He’s been a provider (pediatrics), an academic (current faculty member at Harvard Medical School), businessman (CEO of IHI), and quality improvement visionary (IHI leads many cutting-edge programs that aim to move the industry beyond the status quo; one example is Pursuing Perfection, a $21-million initiative of the Robert Wood Johnson Foundation).

He’s listened to patients relate heartbreaking tales of tragedy, and even though he’s heard his share of inspirational success stories as well, he wants the industry as a whole to stop talking and start doing.

He has recently started borrowing a political maxim: “Some is not a number; soon is not a time.” During his opening presentation at IHI’s 2003 meeting, he asked attendees which would happen first: Americans get the healthcare system they need and deserve, or the Red Sox win the World Series?

“I bet against Boston,” says the avowed member of Red Sox Nation. “My mistake. What I should have done is set a deadline for fixing healthcare.”

A man who rarely makes the same mistake twice, he now has a very specific, time-sensitive plan: to save 100,000 lives by 9 a.m., June 14, 2006. It will be accomplished by launching IHI’s “100,000 Lives Campaign,” which aims to incorporate six changes into 1,600 U.S. hospitals within the next year and a half. The words “some” and “soon” don’t appear anywhere in his game plan.

THE BIG SIX
The Campaign’s six change initiatives are:

■ The creation of Rapid Response Teams to
intercept unexpected deterioration of inpatients;

- Developing reliable, evidence-based care for acute myocardial infarction (AMI) to reduce mortality due to heart attack;
- Increased use of the so-called ventilator bundle, a set of scientifically validated processes used for management of ventilated patients to prevent ventilator-acquired pneumonia;
- Increased use of the central line bundle to keep indwelling venous catheters from becoming infected;
- Prevention of surgical site infections, largely by reliable use of appropriately chosen and appropriately timed perioperative antibiotics; and
- Prevention of severe adverse drug events through the use of so-called medication reconciliation procedures.

“The problem now is very clear: The buck stops not with the workforce, but with governance and senior leadership,” Dr. Berwick says. “The improvements will happen because of senior leadership, or not at all. The front-line workers are ready, willing and able to implement the six changes we need to meet that goal of 100,000 lives saved.

“But the attention of the strategic leaders in healthcare has not been focused on the improvement of care. The strategic objectives have focused on more traditional goals such as growth, marketing and capital development. We need leaders to create a new future, not defend the status quo.”

His goals are aggressive, but Dr. Berwick is not asking those leaders to fly blind. The six initiatives he identified are proven to be successful. Rapid Response Teams, for example, have demonstrated their worth in real-world healthcare settings. In a 1999 article published in the Australian Medical Journal, authors reported a 27% decrease in hospital mortality rates from this single intervention alone.

**BUNDLING IS BETTER**

When speaking with Dr. Berwick, the concept of “bundling” comes up frequently. Getting medical facilities to adopt this concept won’t be easy, however, because it’s much harder on results than the current system.

For example, it is widely accepted that there are specific things that should happen when a patient presents with AMI:

1. early administration of beta-blockers and aspirin,
2. beta-blockers and aspirin at discharge,
3. an ACE inhibitor or angiotensin receptor blocker at discharge if they have systolic dysfunction,
4. timely reperfusion, and
5. smoking cessation counseling.

If 100 patients with AMI came into a hospital and 90 of them received beta-blockers at admission, compliance would be 90% for that intervention, according to standard methodology. “Currently, we score our reliability for those interventions as a list of numbers, one for each item—90% for beta-blockers at admission, 95% for aspirin at discharge, and so on,” Dr. Berwick says.

“What we at IHI want to do is grade healthcare on a pass/fail basis on the whole bundle of interventions. A hospital would get a ‘yes’ if it did everything it was supposed to do for a patient, and a ‘no’ if anything—even one of them—was left out. We at IHI call the bundled scoring system ‘raising the bar on performance.’”

As with the Rapid Response Teams, there is hard scientific evidence to back Dr. Berwick’s claims on reliable AMI care. Hackensack University Hospital (Hackensack, N.J.) and McLeod Regional Medical Center (Florence, S.C.) are two organizations that were willing to adopt the more stringent system, and had to make numerous changes to accomplish it: using standard protocols for care, providing reminder systems and changing job designs. They achieved a 50% reduction in inpatient AMI mortality rates in less than a year.

**CRUNCHING THE NUMBERS**

When a 500-bed hospital implements all six strategies, here’s what Dr. Berwick believes would happen:

- If the Rapid Response Teams were able to reduce hospital deaths by 10%—less than half of the 27% achieved in the Australian facil-
If all patients received the proper AMI care, it would cut mortality 50%, saving approximately 50 lives.

■ An 80% reduction in ventilator-associated pneumonia and lethal drug errors would each prevent about 10 deaths.

■ An 80% reduction in surgical site infections would save 30 lives.

■ Proper prevention of central line infections would prevent 10 deaths.

The grand total: implementing those six interventions in a 500-bed hospital would save 230 lives per year.

Let’s be more conservative with that number,” Dr. Berwick says. “Let’s say we achieved about half of that … 125 lives per year. That’s one life per four beds in that hospital. If that’s our estimate, to prevent (or at least delay) 100,000 deaths in a year, we would need to implement those six improvements in 400,000 hospital beds.

“Those’s our hard count: six interventions, 1,600 hospitals, 400,000 beds, 100,000 lives saved.”

Some is not a number.

NO TIME LIKE THE PRESENT

Dr. Berwick is mobilizing the 100,000 Lives Campaign with a few tricks he picked up from his son Dan, a veteran in the world of politics.

“Campaigns have field operations—so do we,” Dr. Berwick says. “If an average-sized hospital has 250 beds, that means we’ll need to get 1,600 of them—about one third of the total in the United States—to achieve our goal.

“Campaigns have message discipline, so we need to impart our message in such a way that it can help where it’s needed. We must meet each hospital on its own terms. If making all six changes is too much, how about three? How about one?”

“Campaigns have motivation. We created a series of seven videos, supported by the Robert Wood Johnson Foundation, based on the many lessons we learned during our Pursuing Perfection Initiative. IHI is now making them available for purchase to anyone who wants to see them, and I encourage everyone to do so.

“In our campaign, I don’t even hope that the majority of healthcare organizations are ready to make improvements in their core strategy. But I deeply sense that a substantial and important minority is. That’s the group we’re trying to appeal to.

“When all is said and done, maybe you aren’t one of the hospitals we need to target,” he concludes. “Maybe you’re already there. Still, I have one minor request: Please check your own data and progress. Are you raising the bar, or merely at the bar?

“If you’re sure you are already performing at the highest level, then help the others get to the same place. Be a mentor. Join our campaign staff. Every life saved counts, even if it’s in an organization other than your own.”

Soon is not a time. MHE