

## **The Next Phase – What happens after the June 14 milestone?**

### **What changes in the Campaign after June 14?**

The short answer is: “the effort to improve patient care goes on.” Though we have reached our 18-month milestone—and celebrated our progress with those who took part—there is much work ahead in the coming months, and IHI and all of its partners, nodes, and colleagues will continue to support participants in the months to come. In addition to continued calls, meetings, and tools to support work on the existing Campaign interventions, we will focus on helping hospitals sustain their existing gains and spread good work throughout their facilities and systems, building a firm foundation on which we will launch the next phase of the Campaign in December of 2006.

### **What’s the new aim of the Campaign?**

While the Campaign will maintain its focus on saving lives through the introduction of the existing Campaign interventions, we will also support hospitals in sustaining and spreading their successful work in these areas, asking them to adopt all six interventions throughout their facilities and systems by the end of 2006.

### **Will the Campaign conduct a complete evaluation of its results after June 14?**

Throughout the Campaign, we have been seeking meaningful ways to better understand the Campaign’s results beyond the lives saved count and the information hospitals have volunteered to the Campaign team. For example, we’re very interested in understanding how many of the total lives saved can be attributed to each of the six interventions; we’re interested in understanding which Campaign materials and support vehicles were the most valuable to participants and partners; and we’re interested in understanding the degree to which the standard of care at the intervention level has changed. Leading up to the June 14 milestone, we’ve been thinking of ways to answer these questions, and have several concrete ideas for doing so that we’ll pursue after June 14. In keeping with the spirit of transparency that is at the heart of much of the Campaign work, any results from our inquiries will be made public as soon as possible.

### **Will you introduce new interventions?**

We will not introduce new interventions during the June through December period. We know that organizations have had great success with the six Campaign interventions, and we are encouraging every hospital and system to look closely at making sure interventions are being implemented reliably, to spread the improvements they’ve made to other areas of their facility or other hospitals in their system, and to adopt any of the six interventions to which they have not yet committed.

### **What do you mean by “sustainability” and “spread”?**

In the context of the Campaign, “sustainability” refers to the process of hardwiring successful Campaign interventions into the organization’s systems so that work already begun does not peter out; “spread” refers to disseminating all of the interventions (where applicable) to every unit of every hospital and every facility of every system. In addition to the aim of getting every participating facility to adopt all six interventions, the Campaign and nodes will focus intensively on sustainability and spread in the coming months, offering new tools, calls, and meetings to teach both.

### **What data will we submit after June 14? Will IHI still collect mortality data?**

We will continue to ask hospitals to submit their monthly raw mortality data, as they have been doing. We will also ask hospitals to revisit their “profile” pages and update the information that pertains to intervention spread and sustainability, which will help us gauge our progress towards the June-to-December-phase goal of all hospitals implementing all six interventions in all appropriate

units. Finally, we encourage hospitals to submit intervention-level data to the Campaign in the coming months though that is not required.

#### **Will I still be able to submit data through a Data Intermediary after June 14?**

Our current understanding is that all Data Intermediaries will continue to offer their services to participating hospitals.

#### **Will you be releasing aggregate lives saved information to the public?**

Yes. The aggregate national lives saved figure will be made public on June 14. As we continue the Campaign work, and continue to collect mortality data, it is very likely that we will continue to release aggregate national lives saved results in some form. IHI has no plans to publicly release regional lives saved (at the state level, for example), and will not release individual hospital measure results of any kind, including lives saved, per our confidentiality arrangement with participants.

#### **What will happen in December 2006?**

After the June-December period, we will continue to use the Campaign infrastructure to introduce new interventions to improve care, with the ultimate goals of reducing mortality and morbidity and moving toward a culture of safety in health care. We are working with our faculty experts and partners, and considering suggestions we've heard from hospitals throughout the Campaign, to determine what high-leverage interventions to include in future work. We are very interested in hearing from you about your recommendations for new areas of focus. Please send suggestions to [100k@ihi.org](mailto:100k@ihi.org).

### **Campaign Overview**

#### **What is the aim of the Campaign?**

The 100,000 Lives Campaign is a nationwide initiative of the Institute for Healthcare Improvement (IHI) to significantly reduce morbidity and mortality in American health care. Building on the successful work of health care providers all over the world, we are introducing proven best practices across the country to help participating hospitals extend or save as many as 100,000 lives. With your help, IHI and its partners in this work believe it's possible to achieve this in 18 months (January 2005 through June 2006) and in every year thereafter.

#### **Why did you launch the Campaign when you did (January 2005)?**

Thousands of hospitals and health care organizations are working hard on making health care safer and more effective. They deserve congratulations and encouragement. However, the pace of change in health care overall remains slow and fragmented, and most importantly, patients continue to be harmed. We started the Campaign in the belief that patients deserve a far better system — one based upon best practices that are known to reduce harm and save lives. After years of testing life-saving improvement methods on a small scale, IHI and its partners believe these same methods can and should be implemented rapidly on a much wider scale.

#### **Why did you choose the number 100,000?**

Because we believe that we can achieve this goal in 18 months. Based upon our desire to improve care rapidly and spread these changes broadly, we have engaged over 3,000 hospitals to introduce the improvement interventions at the core of this initiative (see below), and more are joining us every day. It is an ambitious goal, but one that we believe we should pursue in order to give as many patients as possible the care that they deserve.

## **How does the Campaign reduce harm and help save lives?**

IHI and its partners in this Campaign encourage hospitals and other health care providers to take the following steps to reduce harm and deaths:

- Deploy Rapid Response Teams...at the first sign of patient decline
- Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction...to prevent deaths from heart attack
- Prevent Adverse Drug Events (ADEs)...by implementing medication reconciliation
- Prevent Central Line Infections...by implementing a series of interdependent, scientifically grounded steps called the "Central Line Bundle"
- Prevent Surgical Site Infections...by reliably delivering the correct perioperative antibiotics at the proper time
- Prevent Ventilator-Associated Pneumonia...by implementing a series of interdependent, scientifically grounded steps including the "Ventilator Bundle"

When reliably implemented, these interventions will greatly reduce morbidity and mortality.

As the Campaign progresses, participating facilities must also devote attention to holding the gains they make and to spreading successful interventions throughout their hospitals and systems so that we can move on to new challenges together.

## **How do we know these interventions work?**

If you go to the Materials tab [[LINK](#)], you will find fully referenced literature that provides a foundation for each of the recommended interventions, along with success stories and leaders who have led successful implementations.

## **What if we are already doing great work in the six intervention areas?**

It may be the case that your organization is already doing trailblazing work in the areas we've identified for improvement. Nevertheless, we encourage you to check your data, see where you can improve further, and identify new areas for improvement in your organization.

## **What if we would like to pursue another improvement intervention as part of our Campaign activity?**

You are more than welcome to do so. The six Campaign interventions are meant to give hospitals a starting point for action, and we believe that if we engage enough organizations in making these changes we have a chance to meet our 100,000 lives goal. That said, we want to honor all of the important improvement initiatives that are seeking to save lives and combine with all complementary projects and campaigns in pursuit of our goal.

## **There are a lot of quality improvement initiatives out there – how is the 100,000 Lives Campaign aligned with these programs?**

The Campaign is fortunate to have the support of numerous leading national partner organizations that share IHI's commitment to improving the quality of care across the country (for a full listing of Campaign partners please go to the [Participants tab](#)). Together we have gone to great lengths to make sure that our objectives and programs align as closely as possible, allowing you to focus your efforts and consolidate your activity (e.g., we have worked to make sure that our intervention-level measures are consistent with those of JCAHO and CMS). Review a [grid explaining alignment of Campaign interventions with these other initiatives](#).

## **What makes the Campaign unique?**

While there are a number of very worthy national quality improvement initiatives in the country, we believe that the 100,000 Lives Campaign stands out because of its bold aim (saving 100,000 lives),

ambitious pace (trying to meet that aim in 18 months), broad reach (over 3,000 hospitals enrolled), and relentless focus on support for participating hospitals (largely through our national learning network consisting of partners, nodes, and mentor hospitals). In addition, we think the Campaign brings a great optimism to quality improvement efforts throughout the health care industry, demonstrating tremendous levels of cooperation and showing that providers will bring the same level of devotion to this work that they bring to patient care every day. Ultimately, we hope this leads to a lasting change in the standard of care in the country. The dream is that one day our friends and family members will never suffer from the infections and errors that the Campaign targets.

(Note: We welcome your thoughts—positive or negative—on this question, as well.)

### **Is the Campaign only for hospitals?**

We have chosen hospitals as the leading edge of this Campaign because that's where many of the improvements listed above have been introduced and tested (and because more patient deaths due to avoidable errors occur in hospitals). However, everyone who works in health care has an important role to play. Regardless of the setting you work in, if you are a health care professional or administrator, consider the leadership role you can play by influencing your local hospital's leaders and Board of Trustees to join this Campaign. You can also encourage other doctors in your community to pursue the improvement interventions listed above and agree upon associated standards of care. Above all, you can make these improvements yourself (all health care providers, for instance, can contribute to an intervention like medication reconciliation) and be an agent of change and a mentor in your area.

In addition, several of the interventions (e.g., medication reconciliation) have relevance to outpatient settings and we are exploring how we might better engage these practices, along with patients, families, and other stakeholders in the care process in rapid, national improvement.

### **Can organizations outside of the United States participate in the Campaign?**

Yes, we welcome and encourage organizations from outside of the United States to participate in the Campaign. We collect and track mortality data from international organizations, though it does not count towards our domestic 100,000 lives goal. (Note: If you are a Canadian provider, you may enroll directly with "Safer Healthcare Now!" – Canada's related initiative to reduce mortality and morbidity).

As we learn from the experiences of US organizations and Nodes, and from those organizations outside of the US that have launched their own campaigns, we will offer information about how to develop local campaigns.

International toll dial-in numbers are available for Campaign calls and recordings of each call are posted to the web, typically within two or three days of the live call.

### **How is the Campaign funded?**

The Campaign has been funded through several unrestricted educational grants from corporate and private philanthropies, and through IHI's own investment.

### **How does the Campaign address the needs of patients and families? How have Campaign hospitals engaged patients and families in their work?**

The Campaign has encouraged hospitals to engage patients and families in their work—both in their planning for work on the interventions and in implementation. For example, several organizations now allow family members to call the rapid response team at the first sign of patient decline. And organizations have found that encouraging members of their community to carry medication cards at all times eases the medication reconciliation process and decreases the risk of adverse drug events upon hospital admission and discharge (forms available on the Materials tab in the Campaign area of the IHI web site).

Patient- and family-focused explanations of each intervention, including suggestions about how to ensure that patients receive care that is in compliance with appropriate recommendations, are posted in English and Spanish on the IHI website. Organizations are encouraged to distribute these documents to their patients and patients' family members and to discuss with them how the interventions are relevant to their care.

IHI seeks to increase hospital partnerships with patients and families. If your organization has worked with patients and families in the Campaign, and you have a story, tool, or suggestion to share, please email [100k@ihi.org](mailto:100k@ihi.org).

## **How the Campaign Works**

### **We just learned about the Campaign; how do we get started?**

The first step is to let us know that you want to join the Campaign: Please go to the Sign Up tab [LINK] for more information. You can help enroll your organization by encouraging the organization's leaders to take part, and they can enroll by completing the official enrollment form and faxing or emailing it to us to begin the formal enrollment process. There are separate enrollment forms for individual facilities, systems, and partners.

Everything you need to know to implement change at your institution is available for free in the Campaign area of IHI's website; there you will find an overview of the Campaign, detailed information about the interventions, improvement methods, Getting Started Kits, recordings of informational calls, tools, success stories, and resources. We continually add information about experts and peers working on the same changes who are prepared to help you.

To get the most out of all the supports the Campaign website provides, download a [Guide to Campaign Web Resources](#) or take a brief [Campaign Web Site Tour](#).

### **What is a partner?**

Partners are organizations affiliated with the Campaign that are not hospitals or systems – these organizations might include state hospital associations, quality improvement organizations, specialty patient groups and other, similar leverage points that are crucial to us in expanding this work. For a full listing of Campaign partners, please go to the [Participants tab](#).

### **What is a Node?**

Providing effective, timely support to Campaign hospitals on such a large scale requires a robust national network to support implementation and communication – what we're calling Field Operations. Nodes are organizations that have committed to acting as local field offices around the country. A Node may be a large system, an organization such as a hospital association, or a group of organizations working together to form a coalition (Quality Improvement Organizations, Hospital Associations, Medical Societies, etc.). Nodes manage "networks" – collections of approximately 50-100 hospitals grouped by geography, system membership or affinity (e.g., pediatric hospitals, rural hospitals).

If your organization is interested in becoming a Campaign Node, please submit a Node Certification Request Form, available on the Sign Up tab [LINK] of the Campaign area of [www.ihi.org](http://www.ihi.org).

### **Who is my Node?**

Campaign Nodes are high-leverage organizations (e.g., national associations, state medical groups and/or coalitions, big systems) acting as Campaign field offices. Many hospitals want to know if they are required to work with a Node and if there is a particular Node to which they should be assigned. The answer to both questions is "no." Nodes are organizations that have volunteered to give participating hospitals added support in the Campaign, offering their own experience and expertise to help wherever possible; hospitals should take advantage of any node whose services appear

useful to them. Nodes cannot and do not require that Campaign participants join them, but their generosity and assistance are invaluable. See the [Participants tab](#) for a complete list of Nodes.

### **Can I contact other organizations like mine? (What is a Mentor Hospital?)**

Yes, we have a growing list of Mentor Hospitals (hospitals experienced at introducing the Campaign interventions) with representatives available to answer your questions and share ideas. [Click here to see a complete list of Mentor Network organizations](#), organized by intervention, including information on the size and type of mentor facility.

## **Data Submission**

### **What are the data submission requirements for enrolled hospitals?**

Two sets of data are required from hospitals participating in the Campaign:

1. "Hospital Profile" information. This includes data such as number of licensed beds, teaching status, average daily census, etc.
2. Monthly acute care inpatient mortality data. This is the number of inpatient deaths and discharges for a given calendar month. We exclude stillborn, ED-only, and Observation patients from the population, which are generally not considered admissions. Hospitals submit both 18-months pre-Campaign mortality data (July 2003 – December 2004) and Campaign-period mortality data (January 2005 and ongoing). See below for more detailed information on the mortality data and the Lives Saved calculation.

### **Are there any other data submission requirements?**

No. However, IHI provides hospitals with recommended "intervention-level" measures—measures such as *Codes per 1000 Discharges* (a Rapid Response Team intervention-level measure) and *Percent AMI Patients Receiving Aspirin at Arrival* (an AMI Care intervention-level measure)—that we feel hospitals should use internally to track the progress of their work at a more detailed level. Hospitals are not required to submit these measures, but we strongly encourage them to do so and they can use the same method for submission that they use for their mortality data (described below).

### **When should my hospital submit data?**

If your hospital has just joined the Campaign, you should submit your profile data and all available mortality data as soon as your team page is available on our website (key contacts will receive a welcome email with instructions when this happens). After this initial submission of data, hospitals should submit all new available data during the designated quarterly data submission periods:

### **What is the data submission schedule?**

From April 2006 to June 2006, the Campaign will be making a push to have hospitals submit as much data as possible. Hospitals should plan to keep "up to date" with their mortality data by submitting on a monthly basis during this period. Please follow this schedule for the submission of mortality data:

April 1, 2006 – April 30, 2006: At least up through January 2006 mortality data

May 1, 2006 – June 1, 2006: At least up through February 2006 mortality data

Starting in July we will resume the previous pattern of data submission (aligned with JCAHO submission deadlines). The following are designated data submission periods:

July 1, 2006 – July 31, 2006

October 1, 2006 – October 31, 2006

### **How should hospitals submit Campaign data?**

Hospitals may submit data directly to IHI online using an application on our website, [www.ihl.org/extranetng](http://www.ihl.org/extranetng), or hospitals may choose to submit data through one of a few Campaign-authorized "Data Intermediary" organizations, which will then forward the information to IHI. At present Data Intermediaries include ACS-MIDAS+; Ascension; CareScience; Cerner; Hospital Corporation of America (HCA); Minnesota Alliance for Patient Safety (MAPS); Premier; University HealthSystem Consortium (UHC); Tenet; Veterans Health Administration; and VHA, Inc. Recorded training sessions and detailed instructions explaining how to use the IHI data submission tool are available on [www.ihl.org](http://www.ihl.org).

### **Are the data submission requirements different if the enrolled hospital is part of a system?**

Whether or not a hospital is part of larger system, IHI is asking for the same Hospital Profile and hospital-specific inpatient mortality data; we are not collecting mortality data aggregated at the system level. A hospital that is part of a system that has been authorized to act as a Data Intermediary may submit their information through that system, but the data itself will be the same.

### **Will hospital-specific data be publicly reported? What will be publicly reported?**

Hospital-specific data, including Hospital Profile, mortality, and intervention-level data, will NOT be published. With the permission of hospitals, the Campaign will post the name and location of participating hospitals. Our current plans for public reporting include the total number and names of enrolled facilities and systems, and the number of lives saved in aggregate over all Campaign hospitals. We may report additional progress-related information, but always in aggregate so that individual hospital information is not revealed.

### **What if I still have questions about data submission?**

Most questions about data submission can be answered in the [Data Submission How-to Guide](#). The [Data Submission Troubleshooting Guide](#) should also prove helpful. If you still have questions, please email [100k@ihl.org](mailto:100k@ihl.org).

### **Lives Saved Calculation**

For more detailed information, see "[100,000 Lives Campaign – Lives Saved FAQ.](#)"

### **How is IHI calculating lives saved for the entire Campaign?**

Hospitals participating in the Campaign are required to submit monthly raw mortality data (deaths and discharges) to IHI for both the entire Campaign period (January 2005 – June 2006) and the 18 months prior (July 2003 – December 2004). The Campaign calculates the "lives saved" contribution by a particular hospital for a particular month in the Campaign period by comparing that hospital's data for that month to that hospital's data for that month in the baseline period, with a national patient mortality risk adjustment applied to account for the overall change in patient acuity between baseline and Campaign periods. The sum of all these individual hospital months of lives saved over all months and all participating hospitals yields the overall Campaign total lives saved estimate. Note that the baseline period is always 2004; Campaign period months in 2006 are still compared to that month in 2004, not 2005.

### **You've described the lives saved figure as an "estimate"; how confident are you that your estimate is correct?**

The point estimate we've given is our best estimate of lives saved during the Campaign period, using a fairly conservative calculation. However, because of the statistical nature of our approach, it's possible that the number we've given is not exactly equal to the "true" number of lives saved. To give a better idea of the possible range within which the true number of lives might fall, we have calculated upper and lower bounds (XXX and YYY) that describe what we believe to be the reasonable upper and lower limits of where that true number might lie. So, to answer the question directly: we believe that our point estimate is the best single value guess at the "true" value of lives saved, but we cannot say that it is exactly correct. We are very confident that the true value falls in between the upper and lower bounds that we've given.

### **How can individual entities (systems or hospitals) set a goal for number of lives saved?**

One way to set a hospital-specific goal is to determine what level of improvement we need from each participating hospital in order to reach 100,000 lives saved over 18 months. At current levels of national enrollment (over 30 million discharges per year in hospitals participating in the Campaign), participating hospitals would need to average just above 2 lives saved per 1000 discharges over the entire 18 months of the Campaign. For example, a hospital with 10,000 yearly discharges would need to save a total of:

$(10,000 \text{ discharges}) \times (18 \text{ months}/12 \text{ months}) \times (2 \text{ lives saved}/1000 \text{ discharges}) = 30 \text{ lives saved}$

If every hospital (or system) in the Campaign were to achieve this level of improvement, the Campaign overall would reach 100,000 lives saved. Of course, not all hospitals will be able to do this, so, in practice, we need more than the 2 lives per 1000 discharges average from hospitals that are able. Once hospitals have started to have success in their improvement projects and met the 2 lives per 1000 initial goal, they should set higher goals of 3, 4 or more lives saved per 1000 discharges.

### **How can a hospital or system accurately calculate how many lives it has saved?**

Unfortunately, hospitals or systems will have trouble accurately counting their own lives saved using the same approach that the Campaign is using for counting national lives saved (described above). There are two major confounders to calculating lives saved at the hospital or system level using this approach:

1. This particular statistic requires a very large number of patients before it can reach a reasonable level of statistical significance, meaning even very large hospitals are vulnerable to situations in which random fluctuations can overwhelm actual changes in the observed results.
2. Patient mortality risk changes over time might be dramatic, and these changes need to be accounted for in the lives saved calculation; most hospitals don't have immediate access to a mortality risk-adjustment that quantifies these changes.

However, in the spirit of transparency, even though the problems described above limit the power of the calculation, IHI has created a [tool which allows hospitals or systems to estimate their own lives saved](#) using this approach by plugging in their mortality data.

### **How else can a hospital or system track its progress?**

The best and most accurate way to track your progress in implementing the Campaign interventions is by using "intervention-level measures"—measures of the processes or outcomes expected to be directly affected by your intervention work. Compared to looking at overall mortality rates, using these intervention-level measures will give you a much better handle on what progress is actually being made on the front lines.

IHI has provided a set of recommended intervention-level measures, which you can find as "Measure Information Forms" (or MIFs) at the bottom of the [Materials tab](#) in the Campaign area of [ihi.org](#), organized by intervention. When deciding which intervention measures to use, we recommend that you start by looking at these measures.

Hospitals may also be able to estimate lives saved from changes in these intervention-level measures. For example, if you are able to reduce your VAP rate by a certain amount, and you know

that a patient's risk of death increases by a certain amount when they contract VAP, you could calculate the number of patients who would have died with the old VAP rate and compare that to the number of patients you would expect to die under the new VAP rate to produce a lives saved estimate from your VAP work.

### **How many of the lives saved are due to the six interventions? How many of the lives saved are due to the influence of IHI and the Campaign in general?**

The main measurement priority in the Campaign has been to assess the total effects of *all* quality improvements in participating hospitals (i.e. efforts related to the Campaign, and efforts related to other improvement activities as well) but we are also interested in trying to isolate the effects of the six interventions and the Campaign in general.

Our research tells us that there has been a trend of improvement in US hospital quality of care over the last several years--i.e. that US hospitals have been saving lives for the last several years. We believe that the Campaign has accelerated and contributed to this trend, but we have not yet isolated its impact.

Now that we've reached the June milestone, we are beginning to spend more time exploring these questions. As our research progresses, we will make all results public.

### **How do you verify information that hospitals send you?**

Data submitted to IHI are subjected to basic integrity checks (e.g., existence of both numerator and denominator when appropriate, validation that the numerator value is less than or equal to the denominator value when appropriate), and unusually high or low values in a hospital's monthly calculated lives saved per discharge are investigated by contacting the key contact. However, IHI does not audit data abstraction or collection processes at participating hospitals.

The crucial information we collect from hospitals is the mortality data, which are the only measure data used in the lives saved calculation. In terms of data integrity, we are confident in our results—even without hospital site audits—for the following reasons:

1. There is no substantial benefit to a hospital or system to deliberately fake their mortality data; all results are aggregated and we do not comment on individual hospital results.
2. We believe that the most common mistake in data reporting is that operational definitions in the measures are not understood. Mortality measures are very straightforward in terms of these definitions (death is an unambiguous event, for example), so we think hospitals will find it relatively easy to collect these data accurately.
3. Our calculation approach only compares a hospital to itself over time, so even if an operational definition is misapplied, the lives saved results will remain without bias as long as the operational definitions are applied consistently over time.