Update on IHI’s 100k Lives Campaign

**Country:** USA  
**Partner Institute:** The Commonwealth Fund, New York  
**Survey no:** (8)2006  
**Author(s):** Emmi Poteliakhoff  
**Health Policy Issues:** Role Private Sector, Quality Improvement, Others

**Current Process Stages**

<table>
<thead>
<tr>
<th>Idea</th>
<th>Pilot</th>
<th>Policy Paper</th>
<th>Legislation</th>
<th>Implementation</th>
<th>Evaluation</th>
<th>Change</th>
</tr>
</thead>
</table>

1. **Abstract**

In 2004 IHI’s 100k lives campaign to improve patient care identified 6 changes to be put in place voluntarily by U.S. hospitals to save 100,000 lives by June 2006. Over 3,000 hospitals have taken part and IHI estimates that their goal has been surpassed. IHI seeks to continue this work in future, attracting new hospitals and strengthening compliance. The wider importance of the Campaign in crystallizing standards of care for hospitals and catalysing patient safety efforts has been recognised.

2. **Recent developments**

3. **Characteristics of this policy**

<table>
<thead>
<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
</tr>
<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
</tr>
<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
</tr>
<tr>
<td>Transferability</td>
<td>strongly system-dependent</td>
<td>system-neutral</td>
</tr>
</tbody>
</table>

Encouraging adoption of proven interventions is a traditional method of quality promotion in health care. However the IHI Campaign brought **significant innovation** in that it used a deadline and a target number of lives to save via the adoption of specific interventions. Innovation was also shown in the way in which IHI managed to achieve such a groundswell of support amongst all the major parties involved in patient safety from high level national organisations to local groups.

The wider ramifications of the Campaign for all hospitals, in that they go some way to clarifying standards of care for hospitals which could potentially affect their legal liability, mean that its **systemic impact** has been somewhat greater.
than we previously anticipated.

**Transferability** of the Campaign to other health systems could be high, in particular to systems where patients have some choice of provider and providers therefore have an incentive to gain high profile marks of quality.

### 4. Purpose and process analysis

#### Initiators of idea/main actors

- **Government**: The Campaign has been endorsed by several government agencies including the Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention and the Veterans Health Administration.

- **Providers**: The number of provider hospitals joining the campaign far surpassed expectations at over 3,000, approximately half of all hospitals, compared to the anticipated 1,600. Participating providers are diverse in nature and geographically dispersed. The American Medical Association and the American Nurses Association as well as more localised medical organisations have endorsed the Campaign.

- **Private Sector or Industry**: The Campaign has been endorsed by several independent bodies which promote safety in health care including the Leapfrog Group, the Joint Commission on Accreditation of Healthcare Organizations and the National Patient Safety Foundation.

#### Stakeholder positions

The positions of stakeholders have not changed since implementation of the policy. However, the level of support from providers has been higher than predicted. The IHI retains its position of leadership as the Campaign's instigator. Other organisations have taken leading roles as strategic partners in specific areas. For example the American Medical Association has developed two online tool kits specifically to encourage physicians to join the initiative ([www.ama-assn.org/ama/pub/category/15010.html](http://www.ama-assn.org/ama/pub/category/15010.html)). The campaign has met with a high level of acceptance and opposition is limited.

#### Actors and positions

**Description of actors and their positions**

**Government**

- Centers for Medicare and Medicaid Services
- Centers for Disease Control and Prevention
- Veterans Health Administration

<table>
<thead>
<tr>
<th><strong>Idea</strong></th>
<th><strong>Pilot</strong></th>
<th><strong>Policy Paper</strong></th>
<th><strong>Legislation</strong></th>
<th><strong>Implementation</strong></th>
<th><strong>Evaluation</strong></th>
<th><strong>Change</strong></th>
</tr>
</thead>
</table>

**Providers**

- Participating provider hospitals
- Representatives of clinicians

**Private Sector or Industry**

- Institute for Healthcare Improvement

- very supportive
- strongly opposed

- very supportive
- strongly opposed

- very supportive
- strongly opposed

- very supportive
- strongly opposed

- very supportive
- strongly opposed
Influences in policy making and legislation
This is a campaign to encourage voluntary action by hospitals and is not part of the legislative process.

Legislative outcome
n/a

Actors and influence
Description of actors and their influence

Government
- Centers for Medicare and Medicaid Services: very strong, current, none
- Centers for Disease Control and Prevention: very strong, current, none
- Veterans Health Administration: very strong, current, none

Providers
- Participating provider hospitals: very strong, current, none
- Representatives of clinicians: very strong, current, none

Private Sector or Industry
- Institute for Healthcare Improvement: very strong, current, none
- Leapfrog Group: very strong, current, none
- Joint Commission on Accreditation of Healthcare Organizations: very strong, current, none
- National Patient Safety Foundation: very strong, current, none

Positions and Influences at a glance

Adoption and implementation
Successful implementation
Implementation occurred voluntarily within the 3,000 plus hospitals which have been participating in the Campaign. There are a number of other national quality improvement initiatives which have not had the same level of prominence and success as the IHI Campaign. The IHI explain their campaign’s success as the result 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 they cite the optimism which the Campaign brought to quality improvement efforts throughout the health care industry as a major reason for success. Also important was the way in which the Campaign made a strong effort to align its objectives and programs with those of other patient safety campaigns, ensuring that efforts could be focused with no inconsistency of messages to providers (IHI 2006).
Important in avoiding obstacles to implementation was the choice of the 6 planks of the campaign, in which a critical factor was that they should not require major capital investment. This meant that although the planks required some investment of additional staff time and some reprioritization of resources, the interventions were realistic in almost all hospitals (Gosfield and Reinertsen 2005).

### Strong media coverage

Media coverage of the Campaign was unusually strong for a patient safety campaign. For example IHI President Donald Berwick wrote a substantial piece describing the Campaign at its launch in the mainstream Newsweek magazine (Berwick 2005). In addition, in 2005 Managed Healthcare Executive magazine ran a front page about Berwick and the IHI’s Campaign (McCue 2005). It could be argued that high public visibility together with the use of a bold goal for lives to save meant that hospitals were much more likely to sign up than with more traditional patient safety campaigns. This is because they saw the potential for campaign enrollment to be used as a marketing tool in attracting patients and on the flipside, the lack of enrollment as a negative signal about quality which they did not want to give.

### Broad support from health community

The broad support for the Campaign from the wider health community encompassed not only national but also local organizations such as state medical societies, nurses’ associations and quality improvement organizations. These latter groups acted as local campaign offices and could offer more intensive support to smaller networks of participating hospitals. Berwick et al (2006) have argued that this collection of organisations created “a powerful national infrastructure to drive change and future collaborations that could continue to transform the quality of care”.

### Monitoring and evaluation

Participating hospitals agreed to measure their results, with monthly mortality data reported on a quarterly basis and aggregated data to be made public.
The results released as scheduled on June 14th 2006 showed the target to have been met and surpassed, with an estimated 122,342 lives saved over the first 18 months of the campaign. This point estimate has been calculated by comparing for each hospital in each month the mortality rate in the campaign month with the comparable baseline month from 2004. A national patient mortality risk adjustment is applied to account for the overall change in patient acuity between baseline and campaign periods. IHI has also calculated a range which they believe to be the reasonable upper and lower bounds of where the true number lies. These are 115,363 and 148,758.

IHI accepts that there has been a general trend of improvement in hospital mortality statistics over the last several years. They believe, however, that their Campaign has accelerated and contributed to this trend. Neither the impact of the Campaign nor the individual effects of the 6 interventions have been isolated. IHI plans to turn its attention to these questions in future research.

5. Expected outcome

Please see section "Impact of this policy".

Quality of Health Care Services

<table>
<thead>
<tr>
<th></th>
<th>marginal</th>
<th>fundamental</th>
</tr>
</thead>
</table>

Level of Equity

<table>
<thead>
<tr>
<th></th>
<th>system less equitable</th>
<th>system more equitable</th>
</tr>
</thead>
</table>

Cost Efficiency

<table>
<thead>
<tr>
<th></th>
<th>very low</th>
<th>very high</th>
</tr>
</thead>
</table>

Positive impact on quality of health care services

The impact of the Campaign has been significant. Data produced by the IHI indicates a high level of success for the project. Donald Berwick, chief executive of the IHI acknowledges that the methods used mean that the results are not of research quality, however he makes a case that they provide a credible assessment of the Campaign's results and, importantly, were obtained with a minimal level of disruption and added cost (Berwick et al 2006).

Others have commented on the reliability of the claim that over 100,000 lives were saved because of the Campaign and its six interventions. One potential criticism is that adjustments to the differences in mortality by hospital were made according to national changes in the severity of illness and not changes in participating hospitals. Another, which Berwick acknowledges, is that because hospitals have been implementing a range of quality improvement programs at the same time it is not possible to know the specific impact which the IHI Campaign has had (Kowalczyk 2006). Dr Evan Benjamin, vice president for healthcare quality at Baystate Health System in Springfield, Massachusetts said “I don't think anyone will criticize the numbers right now, but over the next year you will see questions about the methodology as people have time to understand it”. Dr Benjamin praised the campaign, however, noting how it accelerated his hospital's involvement with patient safety measures and the dramatic reduction in death rates from heart attacks and surgical site infections which they achieved over the period (Kowalczyk 2006).

Raising the legal stakes for hospitals

Gosfield and Reinertsen propose that the campaign, with its broad support, highly public nature and breadth, geographic dispersion and diversity of participants raises the legal stakes for all hospitals whether they are participants or not. In their words, “...the 100,000 Lives Campaign has, in a single stroke, created an extraordinary national sharpening of focus on a specific set of clinical practices, to make these practices into hospital policy, as it were. The... hospitals' act of signing up for the campaign and the campaign's endorsement by major professional societies and other regulatory and accrediting agencies establish the status of the campaign planks as national standards of care.” This indicates a level of success of the Campaign which goes beyond the 3,000 plus participating hospitals. It suggests that in future the 6 planks of the Campaign will affect the behaviour of all hospitals wishing to avoid legal liability.
6. References

Sources of Information
www.ahqa.org/pub/connections/162_696_5288.cfm#amad

Berwick, Donald, Calkins, David, McCannon, Joseph, Hackbarth, Andrew: The 100 000 Lives Campaign: Setting a Goal and a Deadline for Improving Health Care Quality. JAMA, January 18, 2006; 295: 324 - 327.

Berwick, Donald: Keys to Safer Hospitals, Newsweek, Dec 12 2005.  
www.msnbc.msn.com/id/10312472/site/newsweek/

Gosfield, Alice, Reinertsen, James: The 100,000 Lives Campaign: Crystallizing Standards Of Care For Hospitals. Health Affairs, 24, no. 6 (2005): 1560-1570 doi: 10.1377/hlthaff.24.6.1560

IHI Campaign Website: www.ihi.org/IHI/Programs/Campaign/Campaign.htm


McCue, Michael, Commentary and Executive Profile of Dr. Don Berwick, Managed Healthcare Executive, February 2005.  www.ihi.org/NR/rdonlyres/73125243-4DD8-4CF7-97CC-75027F762031/0/MHE25705e.pdf

Reform formerly reported in
IHI's 100k Lives Campaign

Author/s and/or contributors to this survey
Emmi Poteliakhoff

Suggested citation for this online article