Chasing Zero: Can Reality Meet the Rhetoric?

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Objectives: Leaders from healthcare quality, purchasing, and certifying sectors convened at a national leadership meeting held September 8–9, 2008 in Washington, DC to address issues of Hospital-Acquired Infections (HAIs). This paper provides opinion interviews from leaders who spoke at a session entitled "The Quality Choir: A Call to Action For Hospital Executives" on whether zero HAIs should be the goal of our Hospitals.

Methods: The successes of many hospitals in dramatically reducing their infection rates were examined toward goals of "Chasing Zero" infections.

Results: They agreed that the rhetoric of Chasing Zero HAIs must become reality, that anything less than aspiring to eradicate the risk of giving infections to patients for whom we deliver care is unacceptable.

Conclusion: Every hospital leader must re-evaluate the strategy, structure, and function of their infection control and prevention services toward the following parameters:

- Zero HAIs must be the goal.
- Purchasers will no longer wait for hospital losses to act.
- Forces of harmonization are an unprecedented force.
- New-found hospitals' harmonized standards can move from "playing defense" to "playing offense" against HAIs.
- Leaders must ignite the passion of teams to make rhetoric a reality.
- Real stories about real people communicate through real caregiver values.
- The power trio of governance, administrative, and medical leaders must turn their potential energy into action.
- We have the "what" we need to aim for, the "how" to get the job done, and it is now about engaging the "who" to seize the opportunity.
- Embrace champions to lead the charge.

Key Words: hospital-acquired infections, healthcare-associated infections, national quality forum safe practices, infection control, infection prevention

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Leaders from the quality, purchasing, and certifying sectors of healthcare were convened at a national leadership meeting held in Washington, DC on September 8–9, 2008 to address the issue of Hospital-Acquired Infections (HAIs). The successes of many hospitals in dramatically reducing their infection rates pose the questions:

- **Can we really get to zero HAIs?**
- **Can the rhetoric meet the reality of frontline care challenges.**
- **Should the national community re-calibrate its expectations of hospitals?**

There was unanimous agreement that the answer to these three questions is "yes." This article is the first part of a two part series of proceedings from one session entitled "***The Quality Choir: A Call to Action For Hospital Executives***." The second article proposes the requirements for an idealized design of a hospital infection prevention department, grounded in the new reality of HAIs.

Few would argue that we are not in a national healthcare crisis. Most believe we are at a time when leaders of great hospitals, their supplier companies, and stakeholders from every sector have to pull together to address the problem of hospital-acquired infections.[1] Many hospital leaders feel they are prisoners of the systems that evolved before they took the helm. Warren Buffet, financial guru, noted for his astute observations, has said, "The chains of habit are too light to be felt until they are too difficult to break."[2] These chains of habit are very difficult to break, and it will only be leadership that can break the bondage to the processes of the status quo.

We have experienced decades of healthcare innovation that have led to development of great pharmaceutical agents, software, and technologies of all types; however, the next wave of high-impact innovation may be in the realm of social entrepreneurship by our leaders. This entrepreneurship will leverage the leadership and talent of our hospital governance boards, our CEOs and administrators, nursing leaders, mid-level leaders, and of course, the servant leaders at the front line.

Until now, hospital leaders have been behind the scenes of HAIs, allocating resources and administrating through their managers. Now, the forces of transparency are pulling them from behind a curtain of anonymity into the bright lights of center stage, taking the bows when things go right, facing the music when things go wrong.

The national certifying, quality, and purchasing organizations have provided a harmonized road map for hospital CEOs and senior leaders who have now been thrust into a new and major role.

Under a sea of complexity, long-ignored fault lines in the tectonic plate of health care have finally snapped into a major fracture with unprecedented force. The early shock waves under the waterline triggered a slow-motion chain reaction through sectors of the industry. These layers of energy are combining to form a tidal wave of unprecedented force. First, there were the quality leaders who detected the problems, including Drs. Lucian Leap and Don Berwick.

In 1999, the Institute of Medicine published *To Err is Human*, which reported a shocking estimate of people who die

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from preventable medical errors each year.[3] The Institute of Medicine report, "Crossing the Quality Chasm" then made an urgent call to improve U.S. hospital safety systems.[4] In 2004, the Institute for Healthcare Improvement (IHI) launched the 100,000 Lives Campaign and the 5 Million Lives Campaign, which followed it.

The Joint Commission has aggressively embraced patient safety as a major focus and has recently prioritized infections.[5] Employers who formed the Leapfrog Group refocused consumers and payers to seek safe hospitals through transparency and rewards.[6] The media have turned the public threat of infections into major ratings, and consumers are now voting with their feet and dollars.

In the inpatient prospective payment system final rule for fiscal year 2009, Centers for Medicare and Medicaid Services (CMS) listed a total of 11 hospital-acquired conditions (HACs) that were considered preventable through evidence-based measures, which included certain surgical site infections. As of October 1, 2008, Medicare will no longer pay the additional costs associated with treating these conditions if the hospital cannot conclusively show that the condition was present on admission. Notably, 3 of the 11 are associated with HACs acquired in surgery.[7]

Government leaders have embraced the infection problem as well. The Centers for Disease Control and Prevention estimates that healthcare–associated infections cause almost 100,000 deaths, at a huge cost per year.[8,9] In 2005, the Deficit Reduction Act of 2005 was passed, and CMS began selecting HACs that were determined to be reasonably preventable for "no pay" status if they were hospital acquired, including certain healthcare–associated infections.

These growing layers are rapidly forming an ever-surging tidal wave. The era of no margin, no mission, is over. Cost-control strategies that have kept hospitals safe in the past may now pull them under. This no-outcome, no-income tsunami will affect the entire healthcare community.[10,11]

THE QUALITY CHOIR—HARMONIZATION PARTNERS

Hospitals feel under siege. The CEOs and senior leaders are extremely frustrated, trustees are anxious, and quality teams are overwhelmed. The certifying, purchasing, and quality organizations are challenging them from all directions. Like an orchestra warming up in the early stages, there seems to be no harmony among the chaotic noise. However, The Joint Commission, the Leapfrog Group, CMS, AHRQ, and IHI have agreed to work together in an unprecedented way, through the National Quality Forum (NQF), to address HAIs.

The NQF *Safe Practices for Better Healthcare-2009 Update*[12] contains national standards that target the 6 major healthcare–associated infections: surgical site infections, catheter-related bloodstream infections, catheter-associated urinary tract infections, ventilator-associated pneumonia, and multidrug-resistant infections such as methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile*. In addition to the harmonization partners represented by the authors of this article (NQF, CMS, The Joint Commission, The Leapfrog Group, and IHI), there were additional harmonization partners that produced the *Healthcare-Associated Infections Compendium*,[13] which was used as a source for the practices. These organizations include Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, the Association for Professionals in Infection Control and Epidemiology, and other organizations committed to improving the safety and quality of patient care, including The Joint Commission and the American Hospital Association. This work would not have been possible without the individual leadership of patient safety experts such as Dr. David Classen, vice president First Consulting Group, associate professor of Medicine, University of Utah.

The safe practices of the *Safe Practices for Better Healthcare-2009 Update*[14] that address that HAIs are some of the most harmonized set of practices ever produced and approved by a national consensus process.[15]

The voices of HAI leaders may not yet be a choir; however, their resonance and harmonization is clear.

The following panel discussion was undertaken before a national audience of healthcare leaders—the order and content was slightly modified to produce these proceedings.

Dr. Denham: Dr. Carolyn Clancy has done a terrific job allocating federal research funds to identify best practice evidence across the nation. Now that the mission impossible of harmonization is completed, what are your thoughts?

Dr. Clancy: My first thought is that it is incredibly exciting that these 6 organizations came together to make sure that hospitals and other healthcare facilities can have one set of rules for the road. I am confident that healthcare professionals and healthcare leaders across the country will take this very seriously.

Dr. Denham: Dr. Janet Corrigan plays a very important role in U.S. health care. She leads the NQF, a special organization with the congressionally recognized role of setting standards for performance measurement. She has assembled a group called the National Priorities Partnership, representing stakeholders from virtually every sector that will now set national goals for improving health care. The NQF is also the final common pathway for infection-related safe practices that have been harmonized as a common road map for all U.S. hospitals. (These NQF-endorsed safe practices were released in March 2009).

Dr. Corrigan: I think there is a lot to be proud of, and I am excited about the recent work in patient safety practices because, for the first time, we really have managed to get 6 major stakeholders and organizations to come together and harmonize their expectations as requirements. So this is a big accomplishment.

Dr. Denham: Dr. Peter Angood, the former chief patient safety officer and vice president of The Joint Commission is a trauma surgeon with a very rich clinical background. With his superb leadership of The Joint Commission team, the 2009 update of the NQF Safe Practices was synchronized with the National Patient Safety Goals of The Joint Commission.

Dr. Angood: What would surprise many healthcare providers about The Joint Commission is that we really listen. We are creating as much change as we can, given the unique role that we occupy within health care. For some, we are a nemesis, we are an irritant, and we are a bother. However, we really do care about what is going on in health care, and we are seriously using our platform to precipitate further changes.

Dr. Denham: The Leapfrog Group was originally founded when leading employers recognized that the major stakeholders in health care were in gridlock. Its goal was to help the market leap over the barriers through transparency. It measures adoption of the NQF safe practices, and many payers have adopted its standards to award purchasing contracts.

Leah Binder, the CEO of the Leapfrog Group, is a former hospital executive. She brings tremendous insight regarding the difficult balance between the challenges of running a hospital with precious few resources and facing the demands of transparency and payers. We ask Leah Binder: what can we expect in 2009 and beyond?

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Ms. Binder: I think, as we are looking at 2009, we are seeing even more harmony among the standards and the measures that are out there to really identify the highest performing hospital, and then, let us hope, with all of us working in concert and together with these harmonized measures, that we will see real, substantial improvements in performance. Seeing an improvement in patient safety across the country is what it is all about.

Dr. Denham: Dr. Don Berwick and his world-class team have unleashed tremendous energy at frontline hospitals. Your original "100,000 Lives Campaign," and the "5 Million Lives Campaign" that followed have had incredible impact. Both were consciously designed to synergize with existing important leadership efforts such as the NQF Safe Practices. Much of the IHI efforts have focused on infections, and it has been a harmonization partner with enormous contributions. Dr. Berwick, now that we have harmonized NQF Safe Practices, what does this mean to you in terms of what you have learned at the front line? How important is harmonization?

Dr. Berwick: Harmonization and alignment of agendas is the most common request we are getting from the front line. The thousands of hospitals involved come back to us often with the request to get it lined up. "We cannot dance to so many different tunes at the same time. Can you all please come together?" We have made a lot of progress now, and I think one of the reasons behind the success of the campaign is that the requests that we are making of hospitals and leaders have become much more harmonized now. The more we do that, the better it will be.

Dr. Denham: The input from the Centers for Medicare and Medicaid regarding the infection-related NQF safe practices was enormous, with commitment right from the top down through the ranks. Dr. David Hunt is a gifted practicing general surgeon, and major contributor to the national Surgical Care Improvement Project. He is currently CMO for the Office of Health Information Technology Adoption in the Office of the National Coordinator for Health Information Technology at Health and Human Services and was a steadfast contributor to the 2009 NQF Safe Practices, representing the Centers for Medicare and Medicaid as our harmonization partner. Dr. Hunt, react to the experience of the harmonization of the practices.

Dr. Hunt: Out in the hospital community, the response has been tremendous. They have a shorter list of initiatives that they have to work on. The benefit, though, is that the much stressed, typically understaffed quality improvement departments in the hospitals do not have to try to herd cats. They can now implement evidence-based standards and practices such as those that have come from the NQF and other groups.

THE POWER TRIO

Dr. Denham: Hospitals that are succeeding in performance transformation have one very clear success factor; their quality choir has a power trio. Governance leadership, the CEO, and medical leadership are three voices of the same chorus. If one is missing, or one is weak, they fall flat.

In the words of Ginny Ueberroth, a hospital trustee in Newport Beach, Calif., "*When we found out how far quality has slipped in all of our hospitals today, we were shocked. As trustees, we had the responsibility to bring the resources to bear, to bring this quality back to the level that it should be and that we all deserve.*"[16]

So what specifically must your trustee know about the NQF Safe Practices for Better Health care?

- First, these national standards were developed using the consensus process described by the U.S. Congress, making them available to Medicare for pay for performance programs.
- Second, there are specifications in the practice-defined specific activities trustees must undertake to be in compliance.
- Third, since these standards have been harmonized across the major stakeholders, they provide cross-credit opportunities for certifiers, payers, and quality organizations.
- Fourth, they provide a road map that can be used to assure accountability of staff and administration.
- Finally, they clearly save lives in all U.S. hospitals.

These standards are evidence based and market proven in thousands of hospitals. In an era of pay-for-performance, they are not just the right thing to do. They are the right thing to do to get paid.

WHAT CAN WE DO BY TUESDAY

Dr. Denham: One of the IHI phrases used to engage the power trio is "Bringing boards on-board." Another IHI expression that we hear everywhere is: "What can we do by Tuesday?" Dr. Berwick, what can hospital leaders "Do by Tuesday"?

Dr. Berwick: I think you heard it in Mrs. Ubberoff's comment, from Hoag Hospital, "It is 'will.'" In execution, you start with "will." So every place is different. It will have its own story, but I will bet that for most hospitals, that is where it should start.

I advise boards and executives to meet the enemy and to stare the problem in the face, not the workforce but the problem.

Talk to patients, investigate cases and bring the patient into the boardroom. If a patient died of an infection, bring the family into the boardroom. Talk to them, and build your own sense that these are real people getting real injuries. We were recently working on pressure sores that are preventable, meeting with a group of CFOs. One of them said, "What is a pressure sore anyway?" Someone ran out and got some pictures. The absolute tide shifted in that meeting.

Dr. Denham: What can quality leaders at frontline hospitals "do by Tuesday"? So many leaders feel that they are captives of their current habits of care. What can you share with quality leaders, safety leaders, and a number of infection control leaders in the audience?

Dr. Berwick: You are unified in the end by your souls and your purposes. You are there to relieve suffering, and anything you can do to recruit that conversation back onto the scene is very important. It may sound naive, but people want to help. Get them to think about that. Harmonization does not mean regimentation. It means harmonization, and in the end, everyone is going to have to sing their own tune in their own way. There is a lot of skill building in what I am saying, so preventing a pressure sore or an infection is a very hard job, although the scientific rules may be standard.

Sometimes, what looks like resistance is simply that we have not invested in the human resource development to help people change their own work.

I really believe that is another piece of the action.

Dr. Denham: Dr. Clancy, "what can we do by Tuesday," knowing the evidence regarding that science of teamwork, the TeamSTEPPS program[17] and so many other great things that you all are doing at AHRQ?

Dr. Clancy: Execution demands teamwork. This is really a team sport, and none of the professionals working in hospitals or healthcare organizations today were trained to be part of a team. You are working with people but not in the way that we need it to happen now. That team, in the case of infections, has to include people who are transporting the patients, people who are doing the radiographs and everything that touches a patient. If

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you do not think about the "how," zero becomes kind of empty rhetoric. I would know that a CEO was serious about doing something by Tuesday because they would be asking "*How*? *How* do you know?" The last comment I will make is about boards. I actually visited a hospital subcommittee of the board that focuses on quality, and it was quite remarkable. They are asking the right questions. I do want to offer one resource to people here. On AHRQ's Web site,[18] there is a healthcare innovations exchange where people share stories and experiences with the intent to improve, and very importantly, they share failures. If they have tried something that sounded really, really easy, you may find out that it is maybe not quite as easy as you thought. So I would recommend that for your attention.

Dr. Denham: It is exciting to see the work AHRQ is developing and supporting. The TeamSTEPPS program is absolutely terrific and has no cost to hospitals. When we meet hospital CEOs who complain of not being able to afford patient safety assets, we ask, "Do you have TeamSTEPPS?" Dr. Clancy, please comment.

Dr. Clancy: TeamSTEPPS is free and very, very empowering. Occasionally, I will get a note from a nurse that says, "Yeah, TeamSTEPPS sounds like a great idea, but tell those doctors they have to be part of the team," and I know where they are coming from. However, for the most part, this concept is like "Wow." TeamSTEPPS got us out of our boxes of saying that it is their fault. We collectively own this issue, and we collectively have the power to do something about it.

Dr. Hunt: I think everything that has been said is dead-on for a "by Tuesday" to-do list. The only thing I would add is to find that clinical champion in your hospital. Sometimes, the champion is your chief of staff. Sometimes, it is a departmental chairman, and sometimes, it is just that clinician that everyone kind of admires. However, find that clinical champion and have a face-to-face meeting with them. Let them know exactly what the plan is. Let them know that what you are trying to do is actually to drive the infection rate down to zero. Zero, again, is a great number. Take the Apollo moon landing for instance, it was very easy to understand where that goal was. President Kennedy could have said, "Well, we want to go into low Earth orbit," and everyone would have said, "Well, where is that?" Zero is easily understood. The moon is very easily understood. You know exactly when you have hit it and when you have not. So that is a great place to go. When you talk about how to deal with surgeons, again, we are a fun bunch. The thing I would say again is what we mentioned before regarding the idea of "not blinking." The evidence is on your side, but also remember that the lingo of surgeons is outcomes, outcomes, outcomes, outcomes. We understand outcomes very, very well. Do not get me wrong. We really appreciate the fact that outcome is a derivative of process, but we also know that no one signs a surgical consent to have a good process. They always want a good outcome. So make your approach up front. Have an upfront conversation with your clinical champion. Explain what you are trying to do, make clear goals in terms of your outcomes, and then, begin to build that team. We often talk about the lack of resources. There are dark green dollars on the table. It is very, very clear, and definitely in the surgical sphere, that you can definitely make dark green dollars by saving that penny. Remember, "a penny saved is a penny earned" because you, in the hospitals, really are spending that money to care for postoperative infections. What we found was that you are going to lose on the order of anywhere from \$2000 to \$8000 above what Medicare will pay for each surgical site infection. Everyone always says, "Well, but that is the other hospital." Our coders can find everything. However, that attitude is like betting against the house in Las Vegas. You are not going to win that game. So there are dark green dollars that are available as a driver. Get your clinical champion on board, and make sure that you have your executive team and the board in place.

Dr. Corrigan: I would encourage leaders, and CEOs in particular, to focus on a strategy for getting the attention of everyone in the institution on HAIs and for motivating improvement. I think part of that strategy has to do with the human side of this issue. Some of us recently went to a conference with approximately 150 healthcare professionals. There were clincians, administrators, and others, and before going to the conference, we were asked to tell a short story about a medical error that had occurred, either to us or to a member of our family. The conference coordinators put that together into a storybook, and I think virtually everyone read those stories before they came in. It was truly a compelling experience for all of us because we realized that most of these, probably all of them, did not need to happen. The book personalized the message of medical error. Everybody in that room had somebody they were thinking about. Sometimes, it was themselves. Sometimes, it was their child. Sometimes, it was a sister. Sometimes, it was a spouse, and sometimes, it was a parent. However, virtually everyone had been touched at a very, very human level. So I encourage leaders to go into the boardroom and go around the table and ask each board member to talk about whether they or a family member have ever experienced an HAI. Hospital-acquired infection is so common. I think you will find that there are a lot of hands that go up at that table. Then, you get a little bit of anger, and anger can be a good thing. A talented leader takes that anger and channels it to a constructive purpose. In this case, the constructive purpose is embracing the goal of zero and going after it. I think the second thing that a leader needs to do in a healthcare institution is to start a very honest and open dialog, as the CEO does with their clinical leadership.

I think one of the things we fail to do in this country is to strike the right balance between professional autonomy and designing good, safe systems within our healthcare institutions.

Professionalism is very important. We all want our physicians and nurses and others to be guided by a strong set of professional ethics that put the patient first. At the same time, we need carefully designed systems that standardize aspects of care and delivery that need to be done right every time for every patient. Sometimes, those two challenges get in the way of each other and bump up against each other. So I think it is time for an open and honest dialog about how we get the most out of professionalism and out of well-designed systems. It is time to try to get everybody around the table focusing on the end game, which is achieving zero.

Dr. Angood: Information is critically important in all of this. The fact, however, is not every healthcare organization out there has the resources. It is fine for us to say "Go off and talk about this with your board." To some degree, this is the choir out here in front of us. You are here because you have already got that vested interest, but most hospitals are small in this country. They are struggling to continue to survive, and they do not know what they really need to focus on. So the information piece is critically important. It is up to the clinical leaders to make sure that the chief executive, their officers, and the Board understand the type of information that is required to address HAIs. What are the epidemiologically important organisms in our organization? What are the antibiotics like and their expense? What is it that we need to do to buff up our systems and our processes? What types of reporting information do you need to have coming out of an information system, whether it is hard copy paper, or some form of an electronic record? There needs to be ongoing, weekly or monthly updates sent to that Board so that the hard

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dollar decisions are made. However, there is still a problem. We need more resources and not just money. It is people, money, and investment in information technology. All of those resources are needed because information is critical.

Dr. Denham: We are starting to get a peek at the power that can be delivered by automated infection surveillance and mitigation systems. We may be seeing the beginning of the beginning of an entirely new breakthrough that may reduce the enormous time commitment of traditional auditing. We all know that we must spend more time on the action. Ms. Binder, please give us a feel for your constituency—the major employers and consumers. What do they expect us to do by Tuesday?

Ms. Binder: Well, I think the first thing they would expect is for us all to learn from each other. I think one of the issues in health care that is different from other industries is that we do not always share information among each other. I will use an example of the airline industry, which has had a very good safety record. They have weaknesses in other areas, but they certainly have a good safety record. One of the procedures that is done in the airline industry is if there is a near miss, a miss, or a fatal accident, the information about that near miss, the root cause analysis, and the preventive strategies that should have been undertaken are shared throughout all of the airlines, all of their competitors. This is a requirement, and it is also shared with employees who would be most affected if it happened to them. We do not do that in health care as often. You do not see hospitals that have a near miss calling the hospital next door and saying, "Listen, we learned something today. Here is how to prevent it. Here is how to prevent an infection. We just learned something." I think many employers are surprised to learn that hospitals do not necessarily share the protocols we learn over time with each other. I think employers would like us to learn from each other, to improve that problem and start talking to each other. We could share our recommendation for what to do by Tuesday, in addition to talking to the CFO about how much savings is involved in reducing these HAIs. I also think that it is helpful and useful for hospital executives to go to visit other hospitals. They could look up the Leapfrog survey online and find a couple of hospitals that do well on it, maybe nearby, and go visit them. They could take a tour, talk to their executives, and learn what they are doing. There are many insights to be gained.

CHASING ZERO HAIS: CAN THE REALITY MEET THE RHETORIC?

The panel was asked 2 questions:

- Can the reality meet the rhetoric—can we really get to "zero healthcare–associated infections"?
- What is their perspective on the power of harmonization (the synchronization of the specifications of measures, standards, and practices down to the detailed level). Is it a catalyst to performance improvement?

Dr. Berwick: With respect to the challenge of aiming for zero, what other number would you pick? I think mature safety systems, in almost any industry I have looked at, do not accept any harm as inevitable to a workforce at risk or to customers. That mentality really counts. It really matters to take every single event as potentially informative and harm as something we are going to try to stop. You might worry, "Well, is it really going to happen? Are we really going to get there? Are people, specifically the work force, going to be demoralized? Is the public going to be scared?" The big surprise for me, in our "100,000 Lives Campaign" and the "5 Million Lives Campaign" is that there is almost none of that. The public has been very mature. They say, "Yes, try hard. We know you are not perfect and may not get there soon, but we welcome the effort, almost always embrace the effort and the workforce." Also, to my surprise, the workforce has just been inspired by those goals. Sure, we need interim goals. We need to say, "Well why don't we reduce HAIs by 50% in the next year?" However, I see no problem at all with putting these goals and aims right on the screen.

Dr. Clancy: The question is—what other number is acceptable? If you are a patient, and you go to the hospital with one problem and emerge with a second problem, you are not really interested in the fine point of preventability. What you want to know is why did I come out with a new problem? I hear this all the time. So yes, I think zero is exactly the right goal. We know that, in some areas, the science is more mature than in others. That is the business that we worry about, but we also know, from our work with the "Keystone Project" in Michigan, that when you combine leadership with actionable information, that when people can track their progress, the results can be dramatic.[19] The results of this project have been dramatic and sustained across the state of Michigan from small rural hospitals to major academic medical centers. So there is something there, and I think this is a huge opportunity.

Dr. Denham: Your AHRQ team provided terrific harmonization support of the NQF 34 Safe Practices. Can you give us the perspective on the value and power of harmonization as we look at the evidence?

Dr. Clancy: I think this is version 3.0 of the Safe Practices, and this is the most harmonized effort, which is incredibly important. Version 1.0 literally was derived from, or based on, a systematic review of all the evidence possible by one of our evidence-based practice centers. We carried over this huge pile of paper, special delivery, hand delivered to the NQF, and the first version of the Safe Practices came out.[20,21] The harmony is incredibly important because we recognize how many demands and different drummers people are dancing to. You simply cannot get there if we do not have aligned practices, and we are not all marching in the same direction.

Dr. Denham: Dr. Hunt, give us your perspective, from the standpoint of Health and Human Services Agency, and as a surgeon, whether zero should be the goal. Is it a reasonable goal for these leaders? Then to follow, do you have any other comments regarding harmonization?

Dr. Hunt: Well, absolutely. You have to get on that path to zero as our goal. The alternative is to concede and admit to being complicit in our national mediocrity. That means that you might as well get your patients together, your surgical patients and your pediatric oncology patients, and tell them that some of them just have to have an infection because you cannot do any better; this is the only way that you know how to do business. This is not really acceptable.

Harmony is absolutely essential. It is so wonderful that you have been able to get in sync with this, particularly with your leadership, Dr. Denham, and the leadership of this panel. I remember when I first heard our former CMS administrator, Dr. Mark McClellan, talk about the change specifically at CMS. At his first all-staff meeting, he said something I had heard no one else say before—that "CMS is an agency of public health." Many have thought that, but no one had actually come along and had the courage to say it. Because of our role, our standing in Health and Human Services Agency, and our influence, CMS has to conduct itself as an agency of public health. That has been huge, and that is why it is so important that we play an important role in this harmonization effort.

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Dr. Denham: National Quality Forum is the final comment pathway, and Dr. Corrigan's leadership has been tremendous. As we watch the NQF role grow, we are all honored to work with you as a team to bring these common measures and standards and practices to the community. What is your perspective? Can the rhetoric meet the reality, or can the reality meet the rhetoric? Second, what is your take on harmonization?

Dr. Corrigan: I think zero is absolutely the right goal for HAI. I do not think anybody here can say with certainty that we can achieve zero, but we can all probably agree that we can get close. So let us start going after it. I think I would not feel bad at all, if 3 years from now, Cardinal had another conference, and we managed to eliminate 95% of infections. How are we going to wipe out the last 5%? That would be a good position to be in. We just need to join forces, push really hard and make this an absolute top priority at the national, community and institutional levels.

Dr. Denham: The National Priority Partners group that NQF has convened is a tremendously representative assemblage of stakeholders—28 organizations from all sectors. It is an amazing expansion of the harmonization story. Dr. Angood, would you address these 2 questions again, as a surgeon, as a representative of The Joint Commission, and as a teammate on this effort of bringing together practical practices? Is zero a reasonable target for a hospital CEO? Is it reasonable to say we are going to go after zero? Will surgeons listen? Does it make sense? Second, your comments regarding the harmony issue?

Dr. Angood: Well, clearly, zero is the number. However, there are some harsh realities. Unfortunately, microorganisms are their own little entities. They mutate as fast as we can create new antibiotics, and so we are going to always have some problem with infections. There are some examples where we have already achieved that target, such as the central line bundle approach. There will certainly be other success stories. This is tough work, however, and we have a long way to go. Remember, we have been dealing with hand hygiene for 150 years, and yet half of us only wash our hands half of the time. So there are some human factor components in here that we just cannot control all of the time. The systems-based approaches we have discussed factor into this further and further. It is a huge and complex set of issues. Harmonizing is clearly the way to go as well. The National Patient Safety Goals fit in nicely with CMS initiatives, fit in with the Safe Practices, and the field is really beginning to feel this overlap. That is the way to continue in the future.

Dr. Denham: Ms. Binder, you represent the big employers such as the Fortune 500 right down to the small employers and even consumers. Can you give us their perspective on chasing zero, as well as the value and the power of harmonization to get there with a group of stakeholders like this coming together?

Ms. Binder: For employers, zero is the only number that is going to work. I think employers are frankly frustrated when they hear about errors and safety problems or when they hear that hand washing hygiene is not necessarily completely in compliance at every hospital in the country. I think most of the public, and certainly most employers that we deal with, are pretty stunned when they hear the statistics on infections. From the employer perspective, there should not be any infections given to their employees by hospitals if at all possible. If hospitals can do brain surgery, they can prevent infections, and so it seems like a simple equation from their point of view. Obviously, it is not a simple equation, and we are aware of that; however, at the same time, it is not an unreasonable expectation that hospitals ought to be able to manage and to prevent these infections. In terms of harmonization, it is extremely positive. I think we want providers to be focusing on getting to zero, not focusing on meeting 100 different measures or 100 different demands from 100 different stakeholders. We want them to focus on what is important. So that is why it has been so positive. I think it is such a good next step in patient safety that all of us have come together with these new measures.

Dr. Denham: Should governance and administrators have a sense of urgency? Do you think we are approaching a flash point with the employers and the purchasers? Have the employers lost their patience with this issue?

Ms. Binder: They lost their patience a while back. This is not new. We are very pleased with the CMS "no-pays," and we are very pleased to see the progress today. However, they are beyond lost patience. There are great frustrations among employers, as I said earlier. It is simply incomprehensible to most employers that the health care system, which purports to be the finest in the world, for which we hear about great technology and great innovation, and new frontiers in health care and curing new diseases, this same brilliant star of the health system cannot solve this fundamental problem. So employers are ready to see change and expect the health care system to take care of it.

CONCLUSIONS

The name of the conference that assembled this panel was "The Chasing Zero Summit." Leaders from quality, purchasing, and certification organizations were in unanimous agreement that both the aspiration and timeliness of chasing zero should be a reality for all hospitals.

Organizations such as the IHI have established the power of the aim to mobilize the troops. The Agency for Healthcare Research and Quality continues to provide us the evidence that demands action. The Centers for Medicare and Medicaid, The Leapfrog Group, and the Joint Commission have provided us the incentives.

Their leaders have established a call to action for each and every governance leader and hospital CEO. They must reevaluate the strategy, structure, and function of their infection control and prevention services. Their message is clear:

- Zero HAI's is the goal.
- Our hospital customers have lost their patience with our inaction—they are not going to wait for leadership any longer.
- The forces of harmonization have formed a wave of unprecedented force.
- The newfound synchrony of harmonized standards must be leveraged to move from "playing defense" to "playing offense to win" against HAIs.
- We are unified by our souls…our leaders must ignite the passion of our teams to make the rhetoric a reality.
- Real stories about real people communicate through the real values of our caregivers.
- The power trio of governance, administrative, and medical leaders must turn their potential energy into action.
- We have the "what" we need to aim for and the "how" to get the job done, and it is now about engaging the "who" to seize the opportunity.
- We must embrace champions to lead the charge.

In the second part of this 2-part series, we will explore the critical requirements to succeed at chasing zero: leadership, resources, and systems.

Zero is the number. Now is the time. This is a defining moment in our health care history.

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