Remembering the 100,000 Lives Campaign

Earlier this week the Institute for Healthcare Improvement (IHI) emailed its weekly bulletin celebrating that it has been ten years since the end of the 100,000 Lives Campaign (Appendix 1). This was the campaign, according to the bulletin, that put IHI on the map. The Campaign started at the IHI National Forum in December 2004, when IHI's president, Don Berwick, announced that IHI would work together with nearly three-quarters of the US hospitals to reduce needless deaths by 100,000 over 18 months. A phrase borrowed from political campaigns became IHI's cri de coeur: “Some is not a number. Soon is not a time.”

The Campaign relied on six key interventions:
- Rapid Response Teams
- Improved Care for Acute Myocardial Infarction
- Medication Reconciliation
- Preventing Central Line Infections
- Preventing Surgical Site Infections
- Preventing Ventilator-Associated Pneumonia [sic]

According to the bulletin, the Campaign’s impact rippled across the organization and the world. IHI listed some of the lasting impacts:
- IHI followed with the 5 Million Lives Campaign – a campaign to avoid 5 million instances of harm.
- Don Berwick and Joe McCannon brought lessons from leading the Campaigns to Centers for Medicare and Medicaid Services (CMS) and the Partnership for Patients.
- Related campaigns were launched in Canada, Australia, Sweden, Denmark, UK, Japan, and elsewhere.

IHI's profile definitely grew. One indicator tracked by IHI was media impressions, which rose to 250 million in the final year of the Campaign. IHI even put a recreational vehicle on the streets to promote their Campaign (Appendix 1). Campaign Manager Joe McCannon was on CNN to discuss the results of the Campaign.

How did IHI achieve such remarkable results in saving patients' lives? The answer is they did not. Review of the evidence basis for at least 3 of these interventions revealed fundamental flaws (1). The largest trial of rapid response teams failed to result in any improvements and the interventions to prevent central line infections and ventilator-associated pneumonia were non- or weakly-evidenced based and unlikely to improve patient outcomes (2-4). The poor methodology and sloppy estimation of the number of lives saved were pointed out in the Joint Commission’s Journal of Quality and Safety by Wachter and Pronovost (5). IHI failed to adjust their estimates of lives saved for case-mix which accounted for nearly three out of four "lives saved." The actual mortality data were supplied to the IHI by hospitals without audit, and 14% of the hospitals submitted no data at all. Moreover, the reports from even those hospitals that did submit data were usually incomplete. The most striking example is that the IHI was so anxious to
announce their success that the data was based on only 15 months of data. The final three months were extrapolated from hospitals' previous submissions. Important confounders such as the background of declining inpatient mortality rates were ignored. Even if the Campaign "saved" lives, it would be unclear if the Campaign had anything to do with the reduction (5). Buoyed by their success, the IHI proceeded with the 5,000,000 Lives Campaign (6). However, this campaign ended in 2008 and was apparently not successful (7). Although IHI promised to publish results in major medical journals, to date no publication is evident.

A fundamental flaw in the logic behind the 100,000 Lives Campaign was that preventing a complication, for example an infection, results in a life saved. Many of our patients in the ICU have an infection as their life-ending event. However, the patients are often in the ICU because their underlying disease(s). In many instances their underlying disease(s) such as cancer, heart disease, or chronic obstructive pulmonary disease are so severe that survival is unlikely. It is akin to poisoning, stabbing, shooting and decapitating a hapless victim and saying that had the decapitation been prevented, survival was assured. IHI also assumed that the data was collected completely and honestly. However, the data was incomplete as pointed out above and the honesty of self-reported hospital data has also been called into question (8).

The bulletin correctly pointed out that Berwick did carry this political campaign with its sloppy science to Washington as CMS' administrator. Under Berwick's leadership, CMS would announce a campaign, have the hospitals collect the data, extrapolate the mortality or other benefit, and prepare a press release. This scheme continues until this day (9). CMS further confounded the data by providing financial incentives to hospitals, often resulting in bonuses to hospital executives, making the data further suspect. Certainly, CMS would not examine the hospital data with skepticism because the success of their campaign was in their own political best interest.

The 100,000 Lives Campaign also had one other outcome. It made many of us who believe in the power of evidence-based medicine to enrich patients' lives to be suspicious of these political maneuvers. To rephrase a well-known quote, "The first victim of politics is the truth". These campaigns certainly financially benefit hospitals and their administrators and politically benefit bureaucrats, but whether they benefit patients is questionable. The bulletin from IHI should be viewed for what it is, a political self-promotion to rewrite the failed history of the 100,000 Lives Campaign.

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References


