

# **Patient Safety Initiatives in Healthcare: Understanding Their Importance to the Supplier**

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# Agenda

- The issue and landscape
- Developing the Value Proposition
- Connecting the Value Proposition
- Translating the Value Proposition
- Implementing the Value Proposition
- Additional resources

# 28 'Never' Events<sup>1</sup>

## Surgical Events

- Surgery on wrong body part
- Surgery on wrong patient
- Wrong surgery on a patient
- Foreign object left in patient after surgery
- Post-operative death in normal health patient
- Implantation of wrong egg

## Product or Device Events

- Death/disability associated with use of contaminated drugs
- Death/disability associated with use of device other than as intended
- Death/disability associated with intravascular air embolism

## Patient Protection Events

- Infant discharged to wrong person
- Death/disability due to patient elopement
- Patient suicide or attempted suicide resulting in disability

## Care Management Events

- Death/disability associated with medication error
- Death/disability associated with incompatible blood
- Maternal death/disability with low risk delivery
- Death/disability associated with hypoglycemia
- Death/disability associated with hyperbilirubinemia in neonates
- Stage 3 or 4 pressure ulcers after admission
- Death/disability due to spinal manipulative therapy

## Environment Events

- Death/disability associated with electric shock
- Incident due to wrong oxygen or other gas
- Death/disability associated with a burn incurred within facility
- Death/disability associated with a fall within facility
- Death/disability associated with use of restraints within facility

## Criminal Events

- Impersonating a health care provider (*i.e.*, physician, nurse)
- Abduction of a patient
- Sexual assault of a patient within or on facility grounds
- Death/disability resulting from physical assault within or on facility grounds

## NQF Serious Reportable Adverse Events

<sup>1</sup>[www.cms.hhs.gov](http://www.cms.hhs.gov)

# Hospital CEO Concerns

*Patient safety and quality ranks second behind financial challenges<sup>2</sup>*

| <b>Issue</b>                            | <b>2008</b> | <b>2007</b> | <b>2006</b> |
|---|-------------|-------------|-------------|
| Financial challenges                    | 77%         | 70%         | 72%         |
| Patient safety and quality <sup>1</sup> | 43%         | NA          | NA          |
| Care for the uninsured                  | 41%         | 38%         | 37%         |
| Physician-hospital relations            | 32%         | 35%         | 40%         |
| Personnel shortages                     | 30%         | 30%         | 30%         |
| Governmental mandates                   | 26%         | 22%         | 23%         |
| Patient satisfaction                    | 22%         | 17%         | 16%         |
| Capacity                                | 16%         | 11%         | 11%         |
| Technology                              | 9%          | 8%          | 8%          |
| Issues about not-for-profit status      | 2%          | 4%          | 3%          |
| Malpractice insurance                   | 2%          | 2%          | 3%          |
| Disaster preparedness <sup>2</sup>      | 1%          | 1%          | 1%          |
| Patient safety                          | NA          | 29%         | 27%         |
| Quality                                 | NA          | 33%         | 29%         |

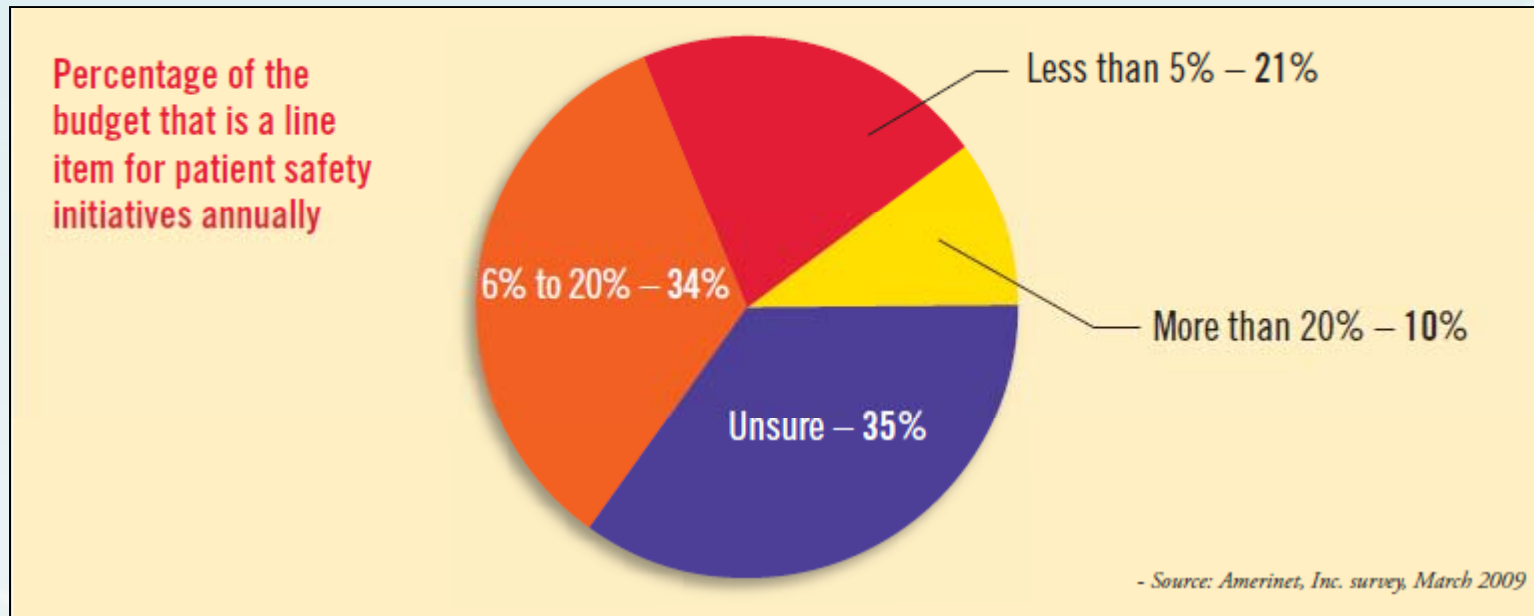
<sup>2</sup>American College of Healthcare Executives, 2008 survey, [www.ache.org](http://www.ache.org)

# Patient Safety and Quality Specific Concerns<sup>2</sup>

- Redesigning care processes 66%
- Redesigning work environment 66%
- Compliance with accred. orgs. 60%
- Medication errors 57%
- Nosocomial infections 47%
- Nonpayment for “never events” 43%
- Pay for performance 41%
- Leapfrog demands 40%
- Public reporting of outcomes data 40%
- Surgical mistakes 24%
- Other 7%

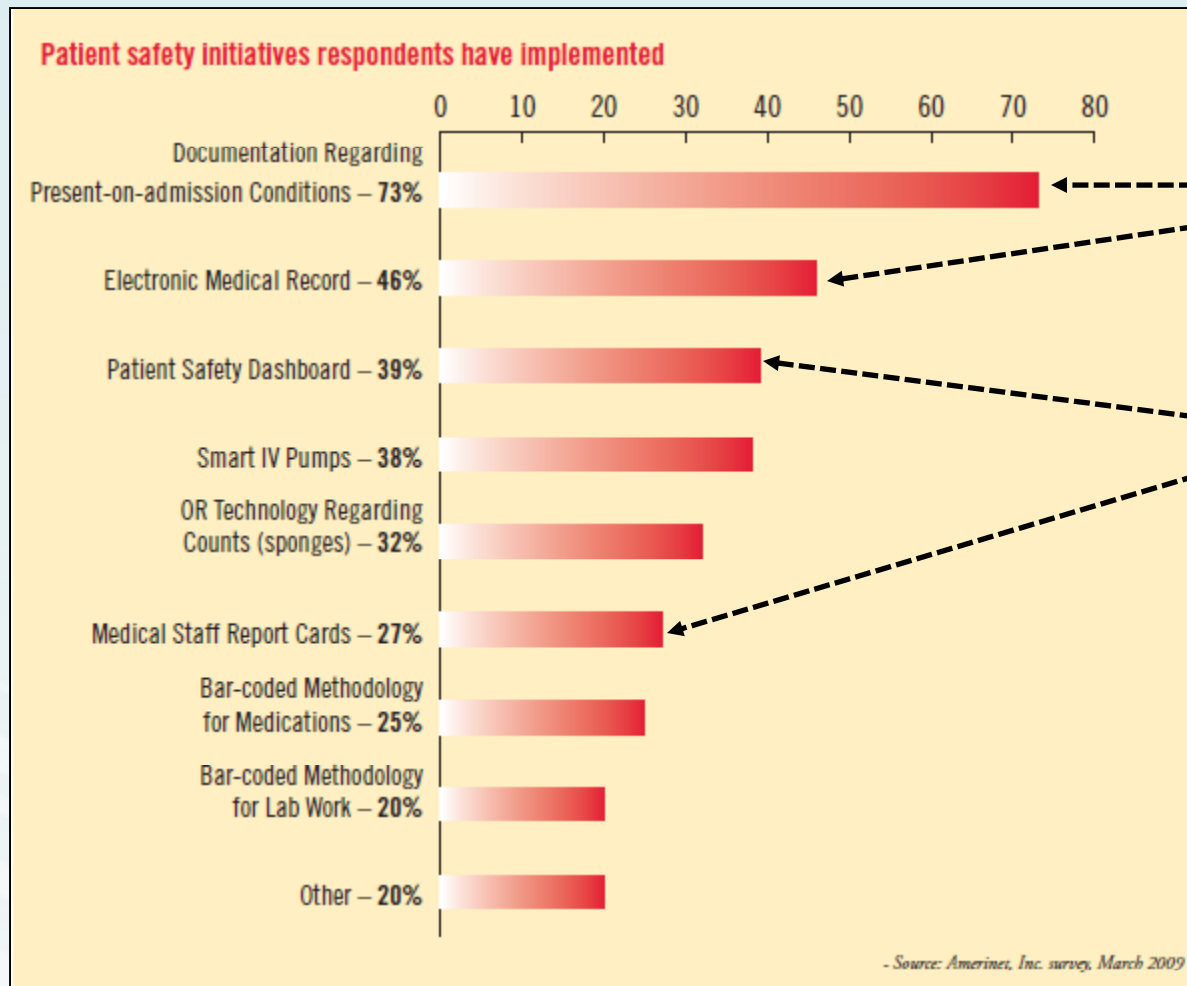
<sup>2</sup>American College of Healthcare Executives, 2008 survey, [www.ache.org](http://www.ache.org)

# Hospitals are funding patient safety initiatives<sup>3</sup>



<sup>3</sup>Quality and Patient Safety: A Sharper Focus; Amerinet Executive Briefing, May 2009; [http://www.amerinet-gpo1.com/anetpub/uploads/2009\\_Executive\\_Briefing\\_QualityDrKaplan.pdf](http://www.amerinet-gpo1.com/anetpub/uploads/2009_Executive_Briefing_QualityDrKaplan.pdf)

# Where is the money going?<sup>3</sup>



Documentation

Awareness

<sup>3</sup>Quality and Patient Safety: A Sharper Focus; Amerinet Executive Briefing, May 2009; [http://www.amerinet-gpo1.com/anetpub/uploads/2009\\_Executive\\_Briefing\\_QualityDrKaplan.pdf](http://www.amerinet-gpo1.com/anetpub/uploads/2009_Executive_Briefing_QualityDrKaplan.pdf)

# **HOW DO YOU GAIN THE COMPETITIVE ADVANTAGE?**

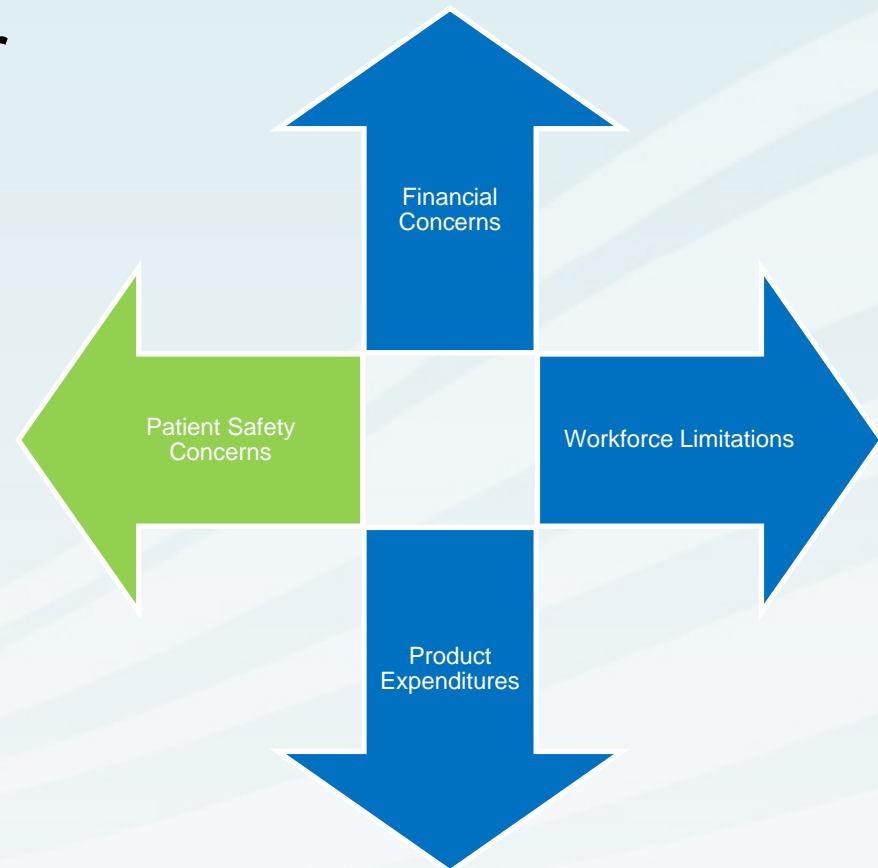
**And your share of the  
patient safety expenditures?**



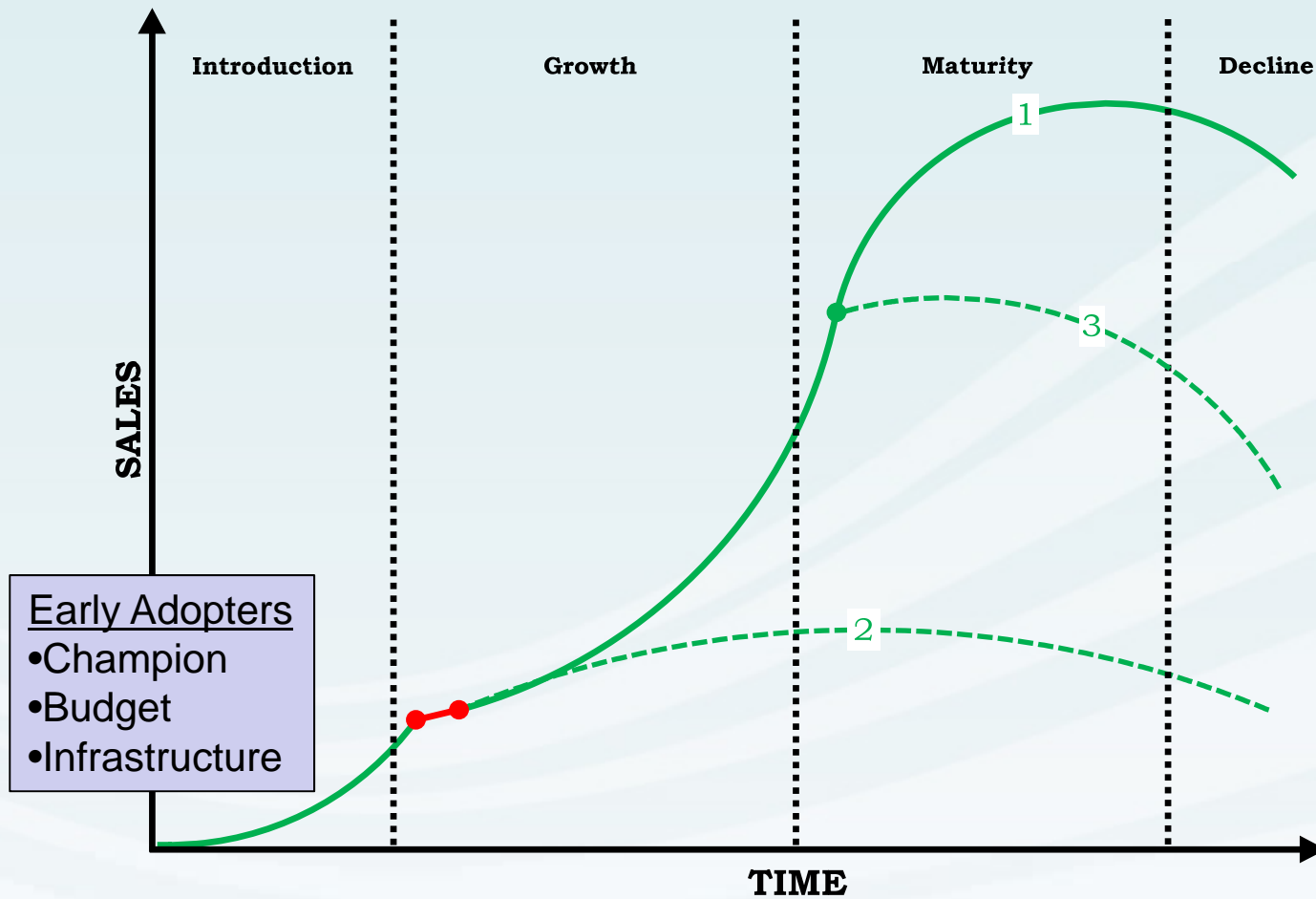
# Healthcare Provider Challenges

Patient Safety is a major concern for providers; however, it is certainly not their only challenge.

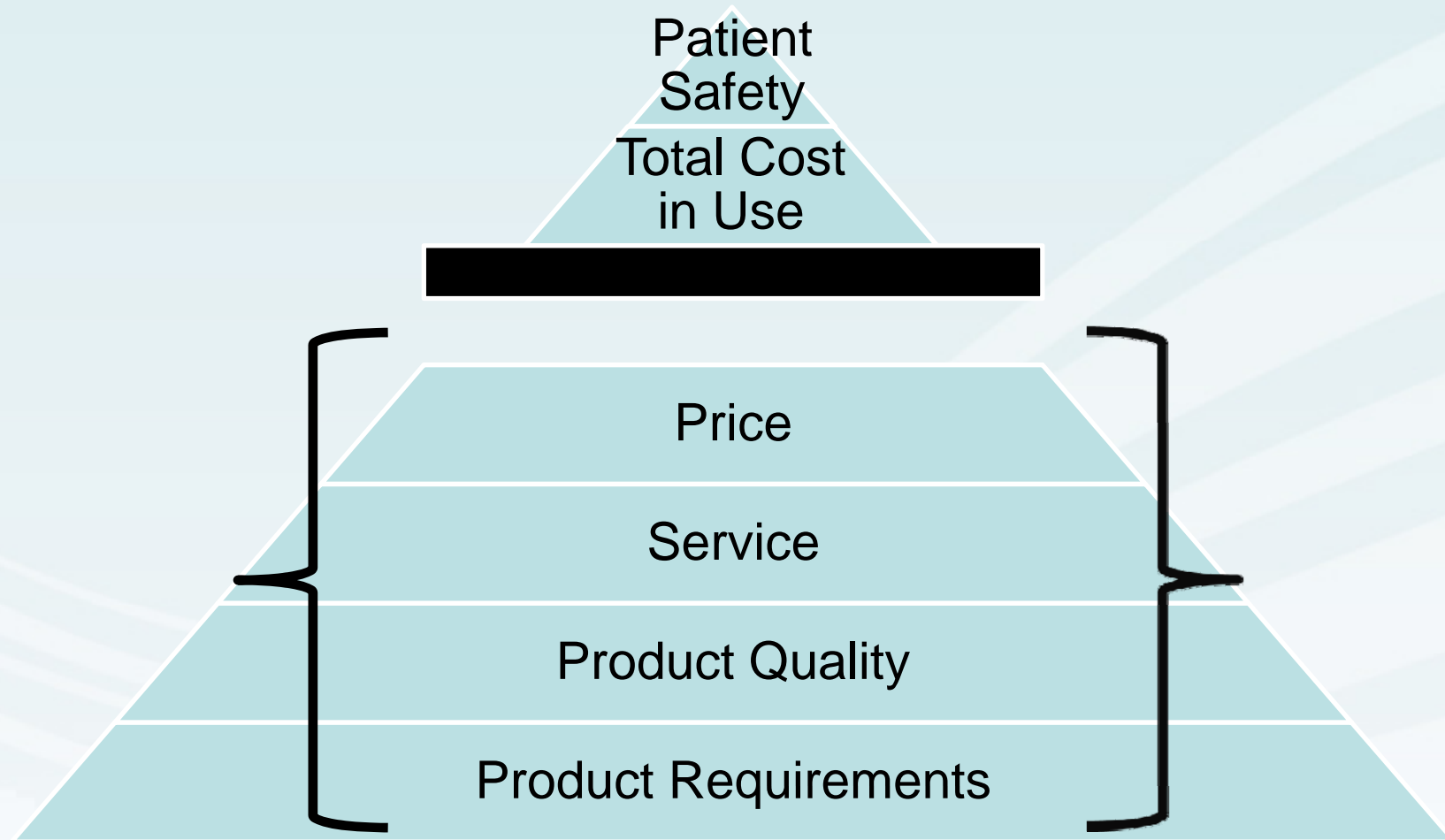
How do their challenges impact the adoption of your products?



# Critical Points in your Product Lifecycle



# Moving Up the Value Pyramid



# Develop the Value Proposition

- Define what your product accomplishes in terms of Patient Safety
  - Our X protects patients by ...
  - Our Y prevents infections ...
- Target your messaging to the provider, and their needs
- Quantify the benefits – address the economic factors which point to the adoption of your solution

# Two Very Different Value Propositions

*Our product enhances patient safety by reducing the infection rates by X%.*

*By reducing infection rates by X%, our product reduces nosocomial infections and saves the average hospital \$Y annually for every 500 surgical procedures.*

*“Everything has become a spreadsheet sale.”*

- Field Representative, major healthcare supplier

Your solution must make sense financially

- Budget neutral, or
- Savings in cost of use, or
- Savings based on clinical outcomes

# Economic Model

- Inputs should be standard measures
  - Admissions, procedures, APD
  - Infection rates
  - Re-admission rates
- Output should include savings and quality improvements
  - Total savings, Net savings (less cost of product)
  - Savings per X (procedures, APD)
  - Reduction of Y%
  - Elimination of Z days of uncompensated care
- Model should have baseline data from other facilities
  - Validation
  - Standard factor
- Model should be user-friendly for all user levels

# Connect the Value Proposition (seed the market)

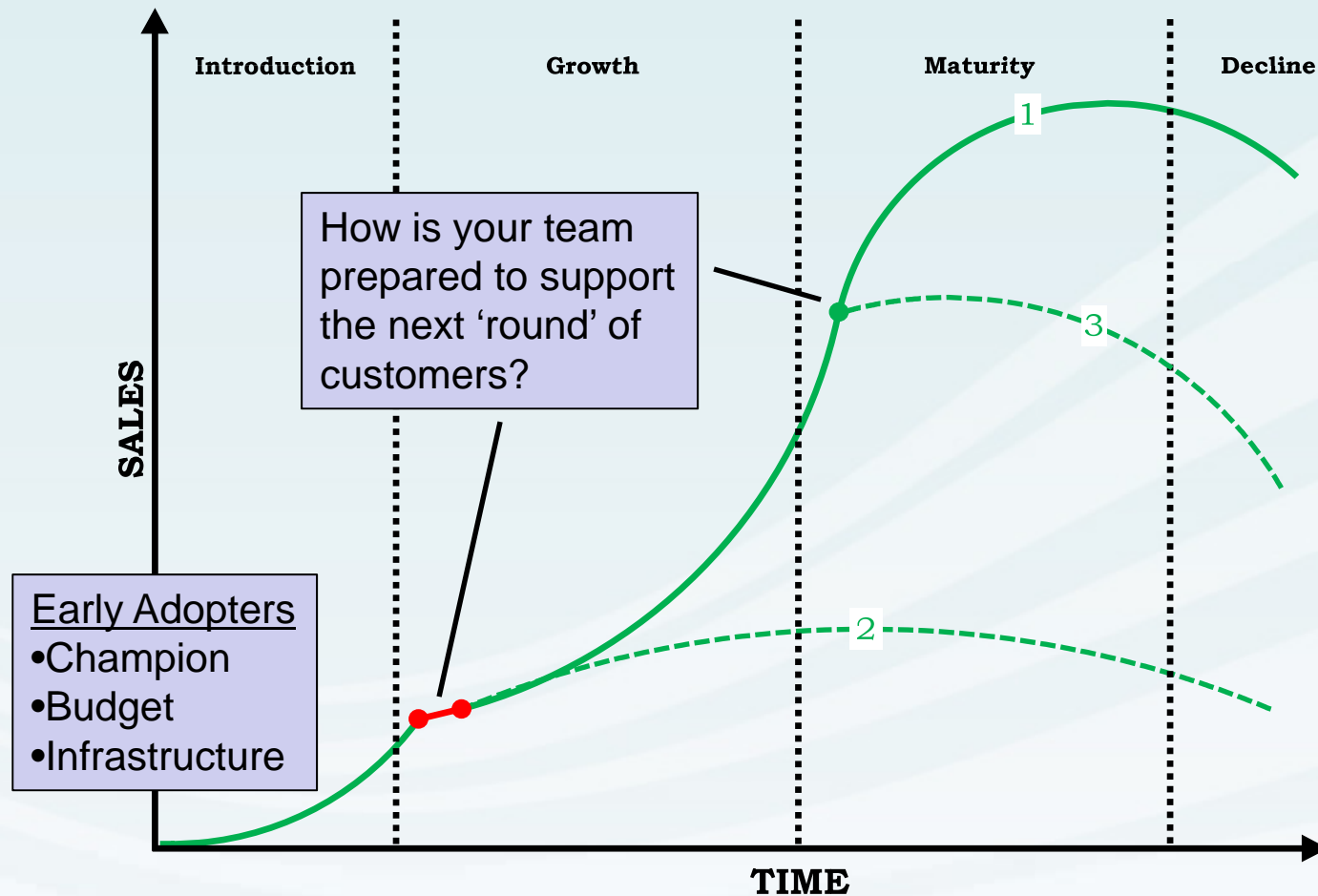
- Find the appropriate organizations
  - Clinical (i.e. AORN, APIC, etc.)
  - Providers (i.e. AHA)
  - ‘Issue based’ (i.e. EpiNet)
  - Group Purchasing Organizations
- Connect to their initiatives
- Support their organization
- Support their initiatives
- Connect to their leaders



# Translate the Value Proposition (engage locally)

- Market your product and solutions to the various stakeholders (clinical and administrative) at the provider level
  - Raise awareness
  - Generate interest
  - Identify your champions
- Connect to organizations
- Connect to individuals
- Identify thought leaders

# Critical Points in your Product Lifecycle



# Implement the Value Proposition

- Provide tools to support the internal sales efforts of the customer champion
  - Economic models
  - Clear outline of implementation support and training
  - Customer success stories, clinical data, etc.
- Develop the tools to facilitate your customers' implementation of your solutions
  - Training tools
    - Pre-packaged implementation kits
    - Online training
  - Reporting tools
  - Monitoring tools
- Align your resources to support the customer
  - Economic 'seller'
  - Clinical support

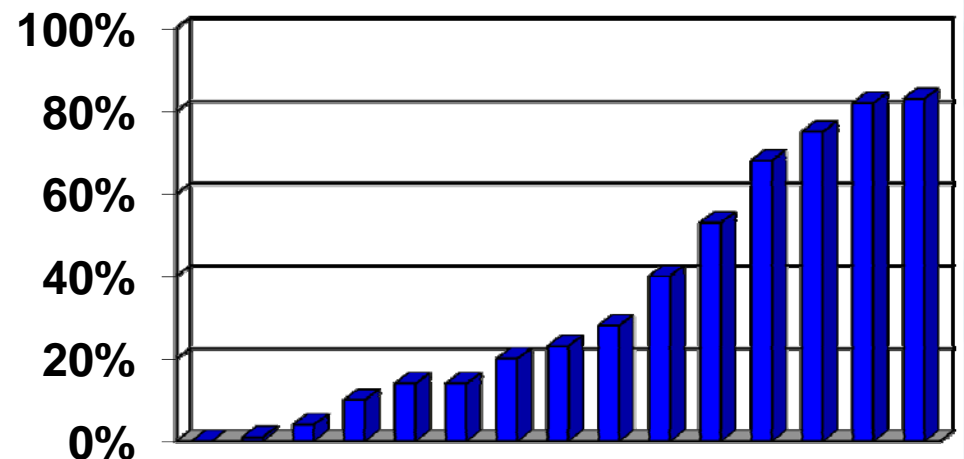
# Are you ready to PARTNER?

- ✓ Demonstrate how the product satisfies the customer's patient safety goals
  - ✓ Share economic models to understand the impact of the change
  - ✓ Engage in planning dialogue
  - ✓ Provide resources to support implementation
- ? Share risk with customers

# Past Successes

- Silver coated urological catheter
  - UTI reduction guarantee
- BIOPATCH®
  - Clinical studies
- Safety IV Catheters
  - Slow adoption
  - Legislation

Safety Catheter Adoption  
1990-2004 (2000-4 proj.)



# Support Tools<sup>4</sup>





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Leaders in Healthcare Safety

*Safety. Savings. Sandel.*

HOME COMPANY NEWS & EVENTS PRODUCTS HOW TO ORDER SUBMIT IDEAS SAMPLES & LITERATURE

TIME OUT® PRODUCTS

### Time Out® Products

|  |   |
|--|---|
| <b>"No-Roll" Skin Markers</b><br> | <b>Time Out® Sleeve</b><br>   |
| <b>Time Out® Hood</b><br>       | <b>Time Out® Beacon</b><br> |

**Problem**  
Wrong-site surgery.

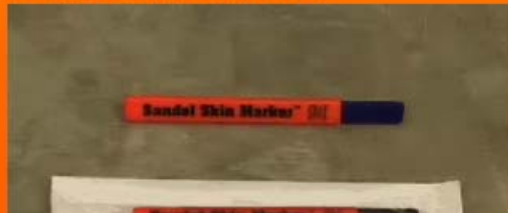
**Solution**  
Sandel Medical Industries' Time Out® Products.

Contact a Sales Representative

Request Samples

View Product Literature

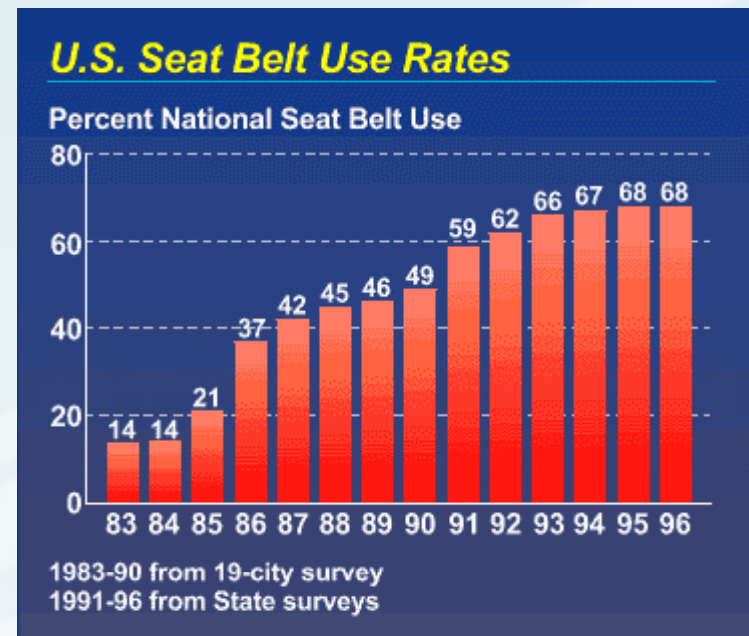
Watch a Demonstration Video



<sup>4</sup> <http://www.sandelmedical.com/time-out-products.asp>

# Recognize the Challenge

- Seatbelt usage has grown as awareness and penalties have grown.
- Despite this, approx. 20% of US drivers still do not buckle up.



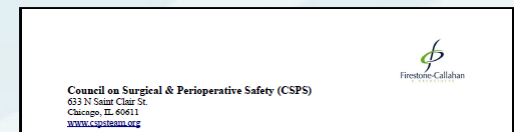
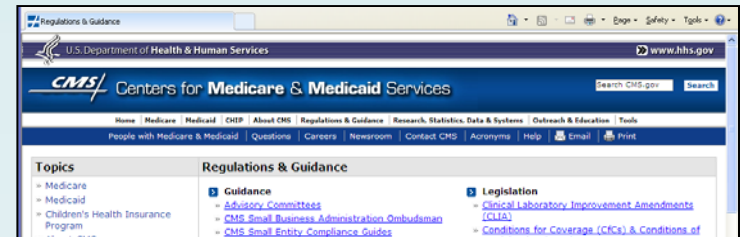
<sup>5</sup> [http://www.nhtsa.dot.gov/people/injury/airbags/Archive-04/PresBelt/america\\_seatbelt.html](http://www.nhtsa.dot.gov/people/injury/airbags/Archive-04/PresBelt/america_seatbelt.html)

# Additional Resources

- Government:
  - CMS, HHS, etc.
- Organizations:
  - JCAHO, APIC, SHEA, etc.
  - List of organizations:

[http://www.firestone-callahan.com/image/Professional Organization Patient Safety Initiatives.pdf](http://www.firestone-callahan.com/image/Professional_Organization_Patient_Safety_Initiatives.pdf)

- GPO resources



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# QUESTIONS?

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