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Suzanne Delbanco: Using Technology to Improve Quality and Patient Safety

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Technology is playing a critical role in improving quality and patient safety, says Suzanne Delbanco, PhD, president of the Health Care division of Arrowsight, Inc. and former CEO of The Leapfrog Group. Using technology to measure the performance of clinical staff and provide them with real-time feedback can help hospitals improve their performance, but improvement requires strong leadership and would benefit from potent payment reform, Delbanco says. She recently talked with hfm about using technology as a tool to facilitate real-time measurement, feedback, and reporting in hospitals.



Q. While you were at Leapfrog, what were some of the things you saw hospitals implement that, in your opinion, had the most significant impact on quality?

A. We attempted to identify changes in hospital practices that could have the greatest impact on patient outcomes, and the most important change we identified was for hospitals with intensive care units to enlist intensivists—physicians who have special training in critical care—to oversee patient care in the ICU. The research suggests that when intensivists oversee patient care, the odds of a patient dying in the ICU are reduced by 40 percent. While I was at Leapfrog—from 2000 to 2007—we saw the proportion of ICUs using this intensivist model of staffing rise from less than 10 percent to about 30 percent. If we were to calculate the number of lives saved during that period, we would be talking about tens of thousands.

The other change that had a significant impact on quality was that Leapfrog implemented the first nationwide effort to get hospitals to report progress on patient safety and quality practices publicly. We opened the door for the Medicare program and state-based programs—although, of course, some states, such as Pennsylvania, had been doing this before Leapfrog—and other voluntary efforts to share data publicly with all those who might need to make decisions about hospitals. Public reporting is going to have a great impact on quality in the hospital setting over the long term.

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Q. What are the next activities or interventions that will have a similar impact?

A. First, there are some very low-tech, low-cost interventions in hospitals that we know can make a big difference for patients. One example is hand hygiene, which I am working on now. We all know that hand washing is extremely important in preventing the spread of infections. Yet the research suggests that, at most, the average compliance rate nationally is about 40 percent. We have a long way to go in helping clinicians remember to wash their hands as they enter and leave patient rooms. But there is no doubt that improving hand hygiene could be one of the most important steps we take.

Second, payment reform could have a large impact on healthcare outcomes. Nothing is likely to be game changing in terms of clinical outcomes if we don't align the incentives properly. We have seen some early examples of how that can make a difference.

Q. What do hospitals need to do to implement these activities or interventions?

A. I wish I could provide a clear recipe for what hospitals need to do to move to the next level of quality and value. The one hard-to-replicate quality that I have seen in hospitals that do an outstanding job is strong leadership. Without the sponsorship of the CEO, CFO, COO, or chief nursing officer, a hospital is unlikely to be able to take on the challenging but important work of improving efficiency, quality, and patient safety. Leadership is absolutely essential.

Q. HFMA's 2009 white paper [Healthcare Payment Reform: A Call to Action](#) notes that payment reform appears to be pointing to incentives for providers to collaborate to reduce costs and improve quality. Some collaboration strategies promoted by organizations such as Bridges to Excellence, PROMETHEUS Payment, and The Leapfrog Group are linking payment to quality, performance, and value. Can you discuss any early lessons learned from these strategies?

A. One early lesson is that no clear model has emerged as the most successful. One of our challenges is that most of the experiments around payment reform, whether pay for performance or other changes to payment, have not been very powerful; the size of the incentive or the reward has been too small to catch the attention of providers. In fact, there are some funny anecdotes about a physician pay-for-performance program in which physicians didn't even realize they were participating and threw reward checks in the trash because they didn't know what they were for. We need a potent-sized reward or incentive to have an impact. Because most of the experiments attempted so far have been wimpy, we haven't seen a particular model become the leading one yet. We do have some research-based evidence that incentives work if they are big enough. That is promising, but again, we haven't seen incentives tried on a scale that could really move the dial in terms of the quality, efficiency, or overall value of health care.

Some of the early lessons come from what is not happening today in the absence of incentives. For example, we are not likely to see any change if physicians lack financial incentive to coordinate with a hospital when patients are discharged, or to work with the hospital to use a cheaper device that they know is just as good as the more expensive one, or to insist that the hospital not send cultures to the lab

every time a patient has a fever after a total hip replacement because almost all patients will have a fever, and as long as it remains low enough, it usually goes down on its own. What physicians say is that if you provide them with the incentive and the feedback around how they are performing in collaboration with the hospital, they will be more likely to stand up and do what they know is right for the patient than they are able to do today.

The HFMA white paper is fantastic. Hospitals are obviously at a very difficult moment in time not knowing what is going to happen with reform. We also don't know what is going to happen in terms of demand on hospital services when the economy recovers. How do you prepare for this uncertain future? The HFMA white paper emphasizes how important it will be for hospitals to be able to adapt quickly to the changing environment—such as being open to and ready for integration—to survive and do well.

Q. Moving forward, what role do you think technology will play in improving hospital quality and patient safety?

A. First, with the financial challenges in our economic environment and with the growing demands on public reporting and measurement in terms of clinical quality, hospitals need the ability to have real-time information on how they are performing on every level, whether clinically or operationally. We need to do everything we can using technology as a tool to facilitate the real-time measurement, feedback, and reporting of hospital performance.

Second, to improve hospital quality and safety, hospitals need technologies that enable them to measure processes that have previously proved difficult to assess. Using the example of hand hygiene again, today our measurement and feedback process lacks both rigor and timeliness. Typically, a clinical observer periodically comes into a hospital unit with a clipboard, counts the number of hand hygiene opportunities that are taken advantage of over the course of a couple hours, and reports that information aggregated with the performance of other units to the hospital every quarter or every year. That approach to measurement for something that should be performed as frequently as hand washing is neither going to provide an accurate picture nor provide enough detail to help improve hand hygiene practices. We need to be able to measure it as it is happening and provide feedback to people while they work in order to get quality and value to the level where they need to be.

Q. What are some of the things that you are doing at Arrowsight Medical to help hospitals improve quality and safety?

A. Following on the framework I describe above, in the critical care setting, we are remotely viewing video of entries into and exits from patient rooms and assessing whether clinicians are washing their hands according to the hospital protocol. We don't just measure it and give them a report every quarter. Instead, every 10 minutes, we provide updates on an LED board that is visible for all in the unit to see. The updates provide an aggregate compliance rate across all nurses and physicians letting them know as a team whether they are washing their hands as frequently as they should. We also provide analytics comparing rooms, shifts, days of week, etc. to identify opportunities for improvement. As one might imagine, that kind of feedback has a remarkable effect on performance and enables teams to improve rapidly and sustain a very high level of performance over time.

We are also working to develop a variety of other patient care applications in the critical care setting to be able to measure and provide feedback on other important procedures such as prevention of pressure ulcers, central line insertions, use of bed rails, and head-of-bed elevation.

Hopefully, the tools for quality improvement and our healthcare payment structures will soon align enough to produce the quality and value we know our healthcare system can achieve.

Suzanne Delbanco, PhD, joined Arrowsight in 2008 as the president of Arrowsight's Health Care division. Previously, Delbanco was the founding CEO of The Leapfrog Group, a national organization driven by major employers and other healthcare purchasers working to initiate breakthrough improvements in the safety, quality, and affordability of care. Before joining The Leapfrog Group, she was a senior manager at the Pacific Business Group on Health, where she worked on the quality team. She holds a PhD in Public Policy from the Goldman School of Public Policy and an MPH degree from the School of Public Health at the University of California, Berkeley. In addition to her duties at Arrowsight, Delbanco is on the Advisory Committee to the Director and the National Biosurveillance Advisory Subcommittee of the Centers for Disease Control and Prevention, as well as on the board of the organization that oversees Bridges to Excellence and Prometheus Payment, Inc.

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