Partnering with Suppliers to Improve Patient Safety

Patient safety officers have a terrific opportunity to improve patient safety by helping their hospitals develop new and improved relationships with product, service, and technology suppliers. This will require a shift in emphasis from traditional products to performance solutions, a leveraging of transparency and pay-for-performance, turning adoption barriers into accelerators, the development of the capacity to define the business case for performance solutions, and the building of true performance partnerships.

"From Products to Performance" and "From Sales to Solutions"

Providers must shift their emphasis from products to the performance those products deliver. Suppliers need to shift their emphasis from generating sales to providing performance solutions.

Historically, the language between these two trading partners has revolved around product features, functions, and price point. Providers and suppliers now need to communicate in terms of the clinical, operational, and financial performance delivered through new solutions. Providers need to put less energy into making a sale and more energy into assuring that the performance implied by the solution they pitch is actually delivered.

We define a performance solution as a product, service, or technology set that enables best or better practices that deliver verifiable performance against process measures, outcomes measures, or structural measures. That being the case, both suppliers and providers need to center their dialog on the same metrics and communicate using the same terms.

Transparency and Pay-for-Performance (P-4-P)

Today when we brief senior leaders, CEOs, and trustees, we usually open the dialog with: “Welcome to the world of transparency. What you do, what goes on at your hospital, where you are in quality and safety performance, will never again be hidden behind the curtains. Transparency is not a fad, it is not a trend; it is a mega-trend.”

Whether or not we want to challenge the estimates of preventable harm U.S. hospitals, we need to face up to them. Our leading safety experts believe the Institute of Medicine’s original estimate of 44,000 to 98,000 annual deaths due to medical error is, if anything, too low (IOM, 2004). Whether the recent HealthGrades report, which estimates the number as high as 195,000 deaths, is totally accurate doesn’t really matter, for this impression has been picked up and communicated by the medical and mainstream media (HealthGrades, 2004; Davies, 2004). Once communicated by the media, perception becomes reality.

In terms of purchasing solutions, we must be prepared to communicate how a new product, service, or solution will reduce preventable death and harm.

As a safety officer, you have an important story to tell. The pay-for-performance “No-Outcome No-Income Tsunami” is a major feature of that story (Denham, 2004). Our hospital administrators currently face unbelievable challenges; however, lurking offshore a tsunami is growing that threatens to swamp hospitals that are unprepared.

Under a sea of complexity, fractures in the bedrock of healthcare quality have converged into a major fault line that has triggered shockwaves to the surface, first detected only by our quality leaders. After those leaders briefed Congress, the Institute of Medicine was engaged to define the problem in healthcare quality and released their initial report in 1999. Shortly thereafter, the Leapfrog Group was formed, and the media actively reported on the magnitude of the problem. Consumers, and ultimately the government, have become engaged in the dialog. With each layer of attention this new wave has grown to very serious proportions. Hospitals are directly in its path.

Dr. Mark McClellan, the new head of the Centers for Medicare and Medicaid (CMS), articulated his vision for patient safety in a recent meeting with us. He said, “It is extremely important. We can’t afford not to move forward on patient safety initiatives today. Medication errors are responsible for thousands of deaths, millions of hospitalizations, and many billions of dollars in added healthcare costs. In an era where we are more concerned than ever about rising healthcare costs, we simply can’t afford not to do anything about it. The good news is that there are more proven methods out there, more evidence available on steps than can be taken by hospitals, by doctor’s offices, by other healthcare organizations to reduce patient safety problems, to improve quality of care, improve outcomes, and avoid the added cost of complication. So we need to get after it now. I intend to do that.”

Concerning CEOs sitting on the fence regarding pay-for-performance, he said, “Those who are on the fence need to...
know that pay-for-performance is here. It’s been a long time in coming, but it’s a top priority for me, for the Secretary, and for President Bush. It’s been a weak spot in our healthcare system. It’s a spot that with rising healthcare costs and greater demand for getting more for our money in healthcare, we can no longer afford to ignore.”

Many hospital leaders feel that operational cost containment has been the anchor that has kept them safe and in place as they have been riding out the rough waves of the 1980s and 1990s. But it may be that this very cost containment behavior pulls them under, unless they invest in patient safety and quality before the P-4-P wave strikes.

It is clear that the purchasers of healthcare, including the Fortune 500 companies represented by Leapfrog and CMS (the world’s largest purchaser), are serious about rewarding quality and safety. This new issue creates a revenue preservation dilemma for hospital leaders. However, it provides a new opportunity for safety officers to discuss the business case for patient safety and to seek additional resources. It also creates new ways to evaluate those solutions offered by suppliers that directly impact quality and safety.

Turning Adoption Barriers into Accelerators

The Leapfrog National Quality Forum (NQF) Safe Practices Program, developed by our Texas Medical Institute of Technology (TMIT) team, provides patient safety officers a framework that can be used for examining performance solutions. The 4-A Accelerator Model, which we have developed and used for technology transfer initiatives, addresses four dimensions pertinent to innovation adoption: awareness, accountability, ability, and action.

Awareness refers to the awareness of hospital leaders to both the performance gaps common to all hospitals and the existing performance gap at their own hospital. Accountability addresses the personal accountability of leaders to closing these gaps. This is the single most important factor to rapid innovation adoption. Ability refers to the capacity to make changes that can be measured in terms of investment in compensated staff time, line item budgets, skill development, and education. Finally, action refers to the explicit actions required to directly close performance gaps.

The early returns from the Leapfrog NQF Program that applies this 4-A model have been gratifying. The survey was designed to create a Hawthorne Effect, so that just the process of undertaking survey submission would raise the dialog up in senior management. The feedback from hospitals shows that it has focused both attention and resource allocation by senior leaders. Barriers along the 4-As were turned into accelerators for patient safety adoption. The same principles can be applied to the purchase and adoption of products, services, and technologies.

Performance solutions can be assessed and selected based on their ability to create favorable results by enabling best or better practices along the dimensions of awareness, accountability, ability, and action.

Hospital leaders and purchasing officers need to ask the right questions of suppliers: “Can you tell me as a supplier that you are fully aware of the performance gap we need to close with your solution? Can you articulate how your solution helps us in a way that I can take to my senior leaders? Who at our hospital needs to be aware of how your solution works? Who needs to be accountable for the adoption of that new technology? What abilities do we need to have throughout the planning and implementation process? And then what actions must we take to get optimal performance from your solution?”

The innovation adoption behaviors of typical market segments provide some explanation of current supplier-purchaser relationships (Moore, 1999; Rogers, 1995). Many of our technology suppliers develop their products from input they receive from innovators, who are typically enamored by new products and adopt based on novelty over performance evidence. However this innovators’ segment represents only a very small fraction of the market. In the next segment, the early adopters want to differentiate themselves in their local markets. They are a small segment that will take on significant risk in adopting new technologies. Together these two segments represent the “early market,” which is quite small and may not be representative of the market as a whole.

Most hospitals in the larger “mainstream market” segments demand evidence for the value of new technologies and solutions offered by suppliers before they are ready to buy. They want to see a real business case and real operational performance impact. They want to know that a similar hospital has had positive performance with that particular solution. Of course, the Catch-22 is that suppliers cannot generate such evidence if it is a requirement of this segment for adoption in the first place. This is why evidence is difficult to find early in a product’s life cycle and why suppliers should invest in generating such results.

Suppliers should be looking for mainstream market hospitals to develop the necessary body of evidence, so that others in their segment will recognize the similar circumstances and barriers. The art of market penetration is to learn from the innovators’ and early adopters’ segments but to design and develop solutions for the mainstream market.

The Blunt End-Sharp End Model, described by Woods and Cook (1998), provides a useful framework for communication. The sharp end can be viewed as the interface between patients and caregivers. The blunt end comprises administration, poli-
cies, procedures, and regulations that can affect the sharp end. This concept may be used in discussions with supplier companies to communicate the interdependence of operations and clinical performance. You can redirect suppliers from their product view to address the full systems of care and enterprise-wide performance.

The role of the patient safety officer with suppliers is to stop the salesman from talking about features, functions, and price, and redirect them to talk about solutions, performance gaps, policies, procedures, inertia, and overcoming adoption challenges. The internal charge is to give clinicians something more to work with than just journal articles on safety. Peer-reviewed research is critical; however we need practical discussions about real frontline performance. Properly primed, the suppliers can greatly help to identify other like hospitals that have adopted their solutions.

**Developing and Communicating the Business Case**

In the new era of pay-for-performance, where competitive forces now come into play, the business case for patient safety has become easier to make. We are seeing the beginning of the end of blind healthcare purchasing. Large purchasers and consumers are much more likely to move their business if a hospital has a quality problem; therefore we can argue that investment in patient safety will protect current market share and win new share.

We have to step up and educate ourselves in the economics and in the performance gaps, both with our suppliers and our senior leaders.

The recent reports cannot be ignored; we are starting to see what poor patient safety is costing our system. It will become very difficult for senior leaders and trustees to ignore an argument that fully frames a hospital’s preventable deaths and harm, the fully loaded cost that this generates, and the modest amount of resources required to prevent these liabilities.

The onus is on patient safety officers to partner with supplier and technology companies to help build the evidence for each business case. We must carefully assess each core product or service in terms of the performance impact they can generate, ask good questions, and demand real tangible evidence-based answers from our suppliers. Not only do we need to understand the impact that supplier’s products have on clinical, operational, and financial performance; we must also assess all the “value adds” that a supplier may provide to accelerate adoption, such as reimbursement strategy support, training, and complimentary resources.

**Performance Partnerships**

Our challenge is to make suppliers our performance solution partners. We must realize that the patient safety officer must be responsible for more than responding to the surveys and providing the educational dimension of patient safety. Safety officers can provide a guiding hand to the purchasing process.

We have to emphasize that the reliability of the entire hospital enterprise is a function of interdependent systems that are enabled by products and technologies. Regardless of the purchasing approach, whether it be a “best of breed” or sole source integrated solution approach, technology affects both the blunt end and the sharp end of care.

Only when we work with our suppliers as performance partners can we develop the best strategy for accelerating our progress down the road of safety. Our best safety officers will help leverage transparency and pay-for-performance, turn adoption barriers into accelerators, and develop the capacity to define the business case for performance solutions with their supplier partners.

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**References**


Denham CR. An Interview with Mark McClellan, M.D., Ph.D. Texas Medical Institute of Technology. April 26, 2004.


