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Chuck Lauer: A Simple Solution to Fall For

Written by Chuck Lauer, Former Publisher of Modern Healthcare and Author, Public Speaker and Career Coach | August 27, 2013

For those of us who advocate for higher quality and patient-centered care, healthcare can be a pretty frustrating industry. With pressures from payers, patients and policymakers at an all-time high, many providers dither, even when there are simple, almost cost-free solutions readily available. Look no further than the simple surgical checklist, which has been proven to prevent as many as 40 percent of deaths from errors such as infections and wrong-person procedures, but is still to be adopted by many hospitals.

I was very interested to read Atul Gawande's recent piece in the *New Yorker* about why some innovations in medicine spread like wildfire while others linger for decades until clinicians adopt them. He looked to history with the spectacular and instant success of using anesthesia in surgery, as well as the painfully slow adoption of Joseph Lister's regimen to prevent germs from entering the operating field.

Dr. Gawande posits that anesthesia combated a visible and immediate problem (pain), while the other innovation took on an invisible problem (germs), whose effects wouldn't be manifest until well after the operation. He also noted that although both interventions made life better for patients, only one made life better for doctors. "Anesthesia changed surgery from a brutal, time-pressured assault on a shrieking patient to a quiet, considered procedure," he wrote. "Listerism, by contrast, required the operator to work in a shower of carbolic acid. Even low dilutions burned the surgeons' hands. You can imagine why Lister's crusade might have been a tough sell. This has been the pattern of many important but stalled ideas."

I work with a couple of companies with truly innovative systems that address some fairly intractable problems, such as overuse of antibiotics and hospital-acquired infections. I have seen some of the same problems Dr. Gawande sees, even though these innovations don't burn physicians' hands.

I marvel at hospitals' unwillingness to adopt low-cost solutions that not only help save lives and prevent serious injuries but also save big dollars, while expensive high-tech gadgets like robotic surgery wind up everywhere almost immediately.

One new technology, provided by a small Michigan company called AvaSure (in the spirit of full disclosure, I serve on their advisory board), illustrates this point perfectly. Its core product is designed to reduce the incidence of patient falls, one of the most difficult

patient safety problems to solve. Falls are on the list of Medicare "never events," so hospitals can't get reimbursed for the estimated average cost of $25,000 to treat the resulting injuries. As many as 15 percent of inpatients sustain a fall, with three in 10 having a serious injury, so we are talking about billions of dollars in lost revenue, not to mention many thousands of injuries and many preventable deaths annually.

Of course, when you say "preventable," you must define your terms. Clinicians have spent years developing complex protocols to evaluate fall risk. Hospitals have spent millions of dollars to have nursing assistants sit with patients who have dementia or other neurological or behavioral issues. Many millions more have been spent on bed alarms, low-rise beds and floor alarms.

The problem is, absolutely none of those interventions solves the problem. Patients deemed to be at medium risk of falling account for most falls. Patients with sitters in the room wind up falling while the sitter sleeps or talks on a phone. Bed alarms go off, but the patient is lying on the floor by the time the nurse arrives.

AvaSure reduces falls at a fraction of the cost of sitters with a simple device — a portable cart with a camera and audio. A trained observer at a central station can watch as many as a dozen patients at once. If a patient tries to get out of bed, the observer vocally intervenes, telling the patient to stay put while a nurse is summoned to help via a dedicated phone line.

Recently I did a site visit to a mid-sized hospital in Michigan that has had the video system for a few years. We watched as an observer kept tabs on seven patients deemed to be at high risk of falling. The observer, formerly a nurse assistant, has learned the tricks of the trade. He reports that he can now anticipate when a patient might try to get out of bed just by his or her facial expression.

The hospital is about to publish the results of a clinical trial showing significantly lower fall rates for patients in rooms with the video/audio monitoring.

Another hospital says its neuro unit, filled with patients at risk of falling, recently went 54 days without a single fall.

Still another hospital has seen six-figure savings from reducing reliance on human sitters — who weren't preventing falls anyway.

AvaSure has done OK for itself, with roughly 40 hospitals having some version of its system in place, but that is a tiny fraction of all hospitals. Just like the surgical checklist, the solution to a core patient safety problem is at hand, but few are adopting it.

I asked the nursing leader at that Midwest hospital why there aren't more hospitals jumping on this solution. She said that in today's economic climate, it is harder to get a signoff from senior leaders for any new spending, no matter what the return on

investment might be.

What she was saying was that amid more pressure to save money and improve quality, hospitals are growing more cautious instead of taking calculated risks that could help them achieve the goals everyone has for healthcare.

If true, that is not a good sign. Unlike in Lister's day, healthcare doesn’t have decades to solve issues of patient safety. This isn't a time for ditherers. Where are the actors?