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Chassin, Loeb cite high reliability as 'next stop' of QI journey

TJC taking leadership role, developing tools to help hospitals

To paraphrase an old TV ad, "When The Joint Commission speaks, people listen." So when **Mark R. Chassin**, MD, FACP, MPP, MPH, president, and **Jerod M. Loeb**, PhD, executive vice president, Health Care Quality Evaluation, co-authored a recent article in *Health Affairs* entitled, "The Ongoing Quality Improvement Journey: Next Stop, High Reliability," you can bet healthcare quality professionals stood up and took notice.

For while the idea of employing high-reliability principles to healthcare quality improvement is not new, an endorsement of this significance is.

Chassin and Loeb assert that it is possible for the industry to both achieve and sustain high and consistent levels of excellence by focusing on three key areas:

- **Leadership:** Leaders of healthcare facilities and systems have to make high reliability a priority.
- **A culture of safety:** This entails an emphasis on trust, reporting unsafe conditions, and improvement.
- **Robust process improvement:** This entails adoption of a range of QI tools and methods, including Six Sigma, Lean, and change management.

KEY POINTS

- Leadership, culture of safety, robust process improvement are key elements of creating high reliability, experts say.
- High level of safety must be maintained over a long period of time over all of the facility's services.
- New methods of calculation are required to accurately measure the level of reliability that has been achieved.

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What is high reliability?

The term "high reliability" certainly sounds like a laudable goal, but what, exactly, is it — and can it be measured? "You judge the existence of high reliability based on no major quality failure, as in airline safety, or nuclear power," says Chassin. "Those industries have close calls but are pretty close to zero in major quality failures. What we're really talking about is the kind of quality problem that has a substantial effect on patients."

In other words, he continues, high reliability entails having reached a "very, very" high level of safety and maintained it over time across all services. "We know there are no highly reliable healthcare organizations anywhere in the world, and it's pretty far out there in terms of what's possible," Chassin says. "Our intention in describing high reliability is to be able to look at other industries that have reached that state and maintained it, and set the bar much higher than it has been in the past."

Small increases in safety from year to year are nice, Chassin says, "but we have to get to no wrong-site surgeries. We have to get to none."

"My definition would be minimal variation — seeing process variation getting less and less and less," adds **Patrice L. Spath** of Brown-Spath & Associates, based in Forest Grove, OR, and lead author of a chapter on 'High Reliability and Patient Safety' in *Error Reduction in Health Care* (Jossey-Bass; Second edition, 2011). "To get to perfect is impossible without spending gobs and gobs of money on high tech and eliminating all your people, because whenever you have people involved, you have variation. The question becomes, which processes need to be highly reliable and in which is it OK to have 90% reliability? You need to sort those things out in setting priorities."

It's important, she continues, to define what you're trying to achieve before working toward your goals. "You can say zero errors is doing it right every single time; the problem is that what might be an error for one patient might be the right thing for another patient, so I don't know if zero errors is my definition," says Spath.

In setting priorities, she continues, "You look at those areas where if our processes are not highly reliable something really bad is going to happen. You can say, is it really important that the admissions person collects information 100% accurately, or is 90% okay? On the other hand, you'd better make sure the right patient gets the right surgery, and that a timeout that occurs better be 100% reliable. In other words, you focus your energy on areas where your 'return on investment' is better."

Is a reliable hospital possible?

Yosef D. Dlugacz, PhD, senior vice president and chief of clinical quality, education and research at Krasnoff Quality Management Institute, a divison of the North Shore - LIJ Health System, and Spath's co-author for the high reliability and patient safety chapter, goes even farther.

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EDITORIAL QUESTIONS

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"In my opinion it's hard to talk of a hospital as a highly reliable organization," he says. "You need to look at small portions of delivery of care, like focusing on the OR or the ICU."

Dlugacz explains: "Those two environments are closed environments with homogenous processes of care. You have a beginning, an end, and a unique culture, which is very important for a highly reliable organization." He points to the Navy as an example. "They identified the process in which they can land a plane safely on a ship in any circumstances — rough seas, and so on. If a plane lands they catch it, and people know exactly what to do when they land."

Dlugacz believes that safe environments can be developed, for example, in ICUs all over the country. "In other words, if you have patients on ventilators you know what to do on self-extubation, or with UTIs you know you can develop measures to prevent sepsis," he says. "If you can implement and measure processes, you can create a potential safe environment with zero problems — no pressure ulcers, infections, or falls."

On the other hand, he notes, units such as EDs do not lend themselves to such an approach. "Because the interests are so varied by unit and each one is episodic care, there is not a defined beginning and end. In the ED you have one diagnosis, and on another floor you'll have another. Also, the patients are all different; a 90-year-old is different than a 30-year-old, and the care processes are very different."

"That's pretty pessimistic," Chassin responds. "I prefer to be optimistic and think we can get there. Just think: A few years ago people thought it was impossible to get rid of central-line infections, but a number of facilities have now done it for years."

Measuring success

How do you measure the reliability of processes? In their writings, Spath and Dlugacz suggest a different method from those traditionally used. "For example, now we measure patient falls by the number of falls per 1,000 patient days; but that's a measure of outcomes, not reliability," Spath says. To calculate the reliability of a system at preventing falls, she offers the example of a facility where there are 4.6 falls per thousand. If you subtract 4.6 from 1,000 and then divide that by 1,000, "You end up with 99.5% reliability — which is a whole lot different than 4.6 falls per 1,000," says Spath.

You must also set reliability goals, she continues, such as goals for timeouts or patient falls. "You should say, 'We want our systems for preventing patient falls to be 99.5% reliable — not to say we're going to get down to two patient falls day," says Spath. "Then, you basically turn to the literature about reliability science to see what works best for preventing mistakes."

"The ultimate measure is if we got rid of major quality failures," adds Chassin. "Part of the challenge is that we are not going to be able to rely solely on measurement of quality processes and patient outcomes. Measurement-driven improvement is an important component, but you have the challenge of developing the safety culture that every high-reliability organization has." *(For more on safety culture, see the sidebar on page 100.)* "There are metrics that help with that, but with a very big organization, there is a change challenge that supports safe operations — but it occurs in parallel with improvement."

One of the most important measurements, as stated by Chassin and Loeb, involves the initial assessment of where your organization stands. "We've done an inventory of a lot of tools out there; we do not think any of them really address the key changes that healthcare organizations need to make today," Chassin says.

Ironically, he says, part of the problem resides in some of the existing tools that focus on the characteristics of a high-reliability organization. "The problem is that while they do a good job of showing how such organizations work, they do not do a very good job of giving us a roadmap of getting from low reliability to high reliability," says Chassin. "You can't just turn a switch in an organization that does not get reports of close calls, or where there is low trust, had very poor measurement and bad leadership, and have them adopt all the ways in which highly reliable organizations work. It's a very incremental process — and that's what we try to lay out."

Ultimately, he continues, "We are looking at all the leverage points we think we can be helpful with in terms of what can be done, and how we can help with how organizations take those next steps."

Part of that process involves the development of a self-assessment tool. "We're just at the point of putting the first prototype together and 'crash-testing' it," says Chassin. The tool is outlined in the paper, he adds, but says that more details will

make it a much more useful and more focused tool to use. "We do not have a fully developed roll-out plan, but we hope within a couple of months to be able to talk more about that," he says.

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Changing the culture is greatest challenge

Of all the keys to achieving high reliability, perhaps the greatest challenge is the creation of a culture of safety. The Joint Commission's **Mark R. Chassin**, MD, FACP, MPP, MPH, president, and **Jerod M. Loeb**, PhD, executive vice president, Health Care Quality Evaluation, outlined a pathway to such a culture in their paper *(See the article above.)* "We borrowed from someone who is probably, in my opinion, the world's leading expert in safety, Jim Reason, who invented the 'Swiss cheese' model, as outlined in the *Health Affairs* article," says Chassin. That framework, he says, is "trust, report, improve."

"First, you must establish all levels of trust that are essential if the environment to high reliability is to be established," Chassin adds. "In high-reliability organizations the culture they establish allows, engenders and demands everyone who works there to define and report problems when they are very small — way upstream from causing a catastrophe."

Such an approach, he explains, makes problems much easier to fix before they fester. "In healthcare, much too often we're behind the 8-ball and looking at patients who've already been harmed and searching for the cause; that's no way to develop a highly reliable organization," says Chassin. "In order to achieve this, workers need to trust one another that they will not be blamed for errors, and trust that management won't either, nor will they sweep problems under the rug — but rather that problems will be dealt with appropriately and will be fixed." Although The Joint Commission has for a couple of years required that organization leaders be responsible for establishing a culture of safety, "we're very far away" from achieving that goal on a widespread basis.

"You can't deny the importance of the culture of the organization; otherwise, reliability will go the way of re-engineering, TQM and everything else that's been thrown at the system and not worked," says **Patrice L. Spath** of Brown Spath Associates, Forest Grove, OR. "You've got to talk about the concept of collective mindfulness, which comes out of the work of Weick and Sutcliffe."

As for quality managers, says Spath, "they should understand the relationship between what happens on the frontlines of care and in an organization so that when expected improvements do not occur or are not sustained at the frontlines, they can make the case to leaders of the importance of looking at the culture and how that is preventing sustainable improvement. That's why they need to become familiar with the concept of collective mindfulness." ■

Teamwork key part of heart failure initiative

Organizations receives GWTG award

The Center for Heart & Vascular Health of Christiana Care Health System, a large healthcare organization based in Wilmington, DE, has received a Get With The Guidelines–Heart Failure Gold Quality Achievement Award from The American Heart Association, signifying that it has reached the goal of treating heart failure patients with 85% compliance for at least 24 months to core standard levels of care. (Those levels of care are enumerated in the American Heart Association/American College of Cardiology secondary prevention guidelines for heart failure

KEY POINTS

- Program improves compliance from 60% to 85% of patients receiving all appropriate care.
- Teamwork helps to identify goals and helps patients meet those goals.
- Physician leadership, hands-on nursing care, and education are critical ingredients for success.

patients.)

"This means that overall 85% of our patients met every single performance measure," explains **Timothy J. Gardner**, MD, medical director of the Center for Heart & Vascular Health and past president of the American Heart Association.

Gardner goes on to explain that in specific areas, compliance was much higher than 85%. "So, for example, smoking cessation was 97%, beta-blockers 93%, and so on," he notes. "That [overall] number is a tricky thing; it asks, how many patients had every single compliance benchmark met? You may have had 97% in smoking cessation, but in getting all patients to meet every single measure, we were at 85%."

Gardner says that the center saw significant improvement as a result of the program. "We went from compliance before the program started of about 60% where patients met every single performance measure," he says. "Even in areas where we were doing pretty well, there was improvement. For example, we were at 87% for patients receiving beta-blockers at discharge, but we moved up to 93%."

Team organization critical

"Prior to initiating the program in 2007, we were very aware of the compliance targets and we were working hard to achieve good quality performance for our patients," notes Gardner. "However, we were not nearly as well organized in team functioning as we became when we joined the program."

Gardner asserts that success was achieved by having all the key members of the team participate. In addition to physicians and nurses, that included social workers, discharge planners, pharmacists, and so on, "working together to identify goals and helping all our patients meet those goals." The overall goal, he says, was to get to 90% or better in all measures.

"Teamwork is recommended as part of the program," Gardner continues, noting that the program contains a wealth of information to help set up your facility's initiative. For example, there is a slide set that reviews the history and rationale for the program. "They have a series of slides that talk about elements for success, which include an initial education workshop on the elements of management of heart failure patients," he says. "Then they talk about having a champion — it's usually a doctor, but it could be a senior nurse or a P.I. individual."

Creating care teams

Next, he says, you put your team together. "The next key element," says Gardner, "was to make everyone aware of the benchmark data — where are we beginning, and what are our goals."

"For us, creating the care teams they recommended really brought together doctors and nurses in caring for the patients," Gardner continues. That involved identifying the key personnel.

"We have over 60 cardiologists, but we knew we needed support from the medical director for the program, so the system took on the responsibility of hiring someone to do that," says Gardner. "We contracted with a heart failure specialist to be our medical director, and also provided him with an NP to allow them to essentially oversee the in-hospital care — and in some instances follow-up care — of many patients."

The nature of medical care for patients with complex conditions is what makes the team structure essential, Gardner notes. "You need physician leadership, dedicated hands-on and well-informed nursing care, and you need to provide education and support for things like nutrition and compliance with medication — you need a village," he explains. "People with different competencies are required to deal with such a complex, challenging situation like a chronic illness."

Next, the team "cohorted" the heart failure patients at the two Christiana hospitals to two particular nursing units, "and spent a lot of time and effort educating nurses on the unit on the patho-physiology and pharmacology and clinical scenarios for heart failure patients," says Gardner. "This included our pharmacy, nutrition people, our social workers and discharge planners, who were not only part of this team but participated in regular rounds with this group — and also interacted with patients and their families."

It's also essential, he says, for those interactions to include both the patient and their family members. "Many patients at home get hands-on care, and if the family is not equally well educated about disease processes and things that either help the patient or make the condition worse, that patient will be back days after discharge," Gardner says.

In order to be sure to accomplish this critical goal, Christiana hired additional nursing personnel and social workers, "to help with the complex transition care of these patients," says Gardner.

"Primarily, that means to help them and their families know what they need to do in terms of medications, exercise, return appointments, and so on, when they leave the hospital."

Measuring results

How does Christiana monitor compliance? "We have a P.I. team, and they use the measurement tools that are part of the program," Gardner explains. "We obviously have to measure a lot of things these days with reports to groups like CMS, and 'Get With The Guidelines' focuses on those we need to document for heart failure management."

Gardner says the team tracks both collective and individual performance and, when required, leadership will consult with physicians. "We would start perhaps with a letter from the PI team that might go something like this: 'Dear Dr. ----, we noted in review of this case that you did not order an ACE inhibitor for this patient despite the fact the guidelines indicate this was the right treatment. Perhaps there was a contraindication, but if so, it was not documented. Could you indicate what it was?'"

If a doctor fails to comply two or three times he or she would get a call from the medical director, Gardner says. "They would have a polite discussion about why the doctor may not have chosen a specific action, and there will be an opportunity for some education," he notes. "Part of our improved compliance has been our ongoing educational effort." The same process, he adds, takes place with nurses, who are "also counseled by their own peers," says Gardner.

User-friendly program

Another key to the success of the "Get With The Guidelines" program, says Gardner, is that it's very user-friendly. "It's sort of set up to help care groups like ours initiate a focus on heart failure patient management," he says. "There was a lot of educational material and structured methodology for our PI team to assess where we were in terms of meeting national benchmarks or best practices for the management of heart failure."

The program includes a number of tools to help the providers get started and work through their performance improvement processes, including:

- **Team meeting tools:** A guide to help leaders organize and motivate their team and get things going.
- **Success stories:** Details about how other hospitals have used the program effectively.
- **Smoking cessation resources:** Numerous tools and tips.
- **Clinical tools:** They include heart failure-specific order sets, discharge instructions, and patient education materials.

The tools, says Gardner, "Forced everyone to look at the data, work together, get motivated, and make things happen."

While Christiana has not formally tracked mortality outcomes, "We have tracked readmissions, and we have reduced them somewhat; we feel we're doing much better with transitions of care," Gardner reports. In addition, he says, "We realized that some of these patients were not able to get back to see their own cardiologists within one or two weeks to make adjustments on their medications, so we started a 'discharge clinic' where we offer to see them within four to seven days of discharge, so we can do medication adjustments and make sure the patient is on the right path."

[For additional information contact Gardner at (302) 733-1241.] ■

Palliative care hardwired into hospital system

Care consultations part of all aspects of hospital care

Palliative care isn't just for hospice patients — it is also used to manage the symptoms of those with chronic or advanced illnesses. One hospital system in Michigan has brought palliative care into all aspects of hospital care for all patients. The efforts of St. John Providence Health System to develop a screening tool for palliative care needs has earned it a spot as one of the recipients of the American Hospital Association's Circle of Life Award — Celebrating Innovation in Palliative and End-of-Life Care.

The health system has integrated palliative care into all aspects of care. "This was a leadership-driven initiative," says **Elizabeth DiStefano**, RN, BSN, coordinator of palliative care services for St. John Providence Health System, Warren, MI. "I didn't have to spend time trying to talk anyone into it. Anything they can do for us, executive leadership is really supportive of the program.

That's really unique — oftentimes people have problems with their leadership, but this was something we needed to provide to the patients," she says.

St. John first introduced palliative care consultations in its hospitals in 2005, but there was no standard in place to identify prospective patients. To solve this issue, St. John partnered with Duke University's Institute on Care at the End of Life to improve the screening process for palliative care needs and develop criteria that all physicians in the system could follow.

Palliative care triggers

"We partnered with Duke to increase access to quality palliative care with increase in attention to spiritual needs,' DiStefano says. "We had five objectives: to screen for palliative care needs, to fully integrate spiritual care with palliative care, educate all associates on basic palliative care, engage the faith community, and institute a culture change for these efforts."

From the collaboration came a trigger tool that medical staff could use to screen patients for palliative care that was pilot-tested in the ICU of St. John Hospital and Medical Center in Detroit, the system's largest hospital. "It was a larger tool that we did. It became cumbersome and lengthy, so we use the top nine triggers from our tool," DiStefano says. "Now, all patients are screened for palliative care needs upon admission, and after five days if they are still in the hospital."

Palliative care triggers include:

- code status changed to DNR;
- conflict about stopping/starting life-prolonging treatment;
- goals of care or code status discussion needed and/or surrogate or proxy distressed about decision-making;
- uncontrolled symptoms that interfere with quality of life;
- marked decrease in functional status/ADLs in last 60 days;
- considering PEG tube placement;
- admitted from extended-care facility with ADL dependence or chronic care needs.

The palliative care process involves more than just physicians — according to DiStefano, St. John's palliative teams comprise a nurse practitioner, social worker and chaplain for a multidisciplinary approach for the patient and his or her family. "We don't just care for the patient — we care for the whole family," she says. "We look at the dynamics, and we look at their needs and if they need spiritual care. The multidisciplinary approach is helpful to the families as well. They have the time to spend with the team to work out the care and what kind of care they want to receive. The team can have those difficult discussions with the family. If they want to see a spiritual care provider daily, they can have daily rounds with chaplains and clinicians."

"I would say that it's an extra layer of support for the patients," DiStefano continues. "Doctors find it very helpful because it saves them time and they don't have to do difficult family meetings. They have found it to be very valuable. We called it value-added care — the value that has been added is an extra team member in there."

However, DiStefano says, attending physicians were initially reluctant to order palliative care consultations. "When we rolled it out, there were issues that were going on," DiStefano says. "Staff education has been very helpful, and the culture has changed over time. Speaking with doctors about it one on one has been helpful, and having the support of the medical executive team has been key."

Response has been 'overwhelming'

In fact, the system has had "mass education from housekeeping staff to the CEOs" on palliative care, according to DiStefano. "We have annual training days and ask staff members to become champions and train four or five other associates," she says.

Response from the community on the program has been "overwhelming," DiStefano says. "I wrote an article about the program for a newspaper for seniors — a little old lady [patient] brought the paper with her to the doctor and said she wanted that kind of care. We have phone calls from the community all the time in support of the program. When people make comments like 'Where have you been?' … it's good feedback from the community."

"We are always willing to share information with other health systems — we want to improve the field of palliative care," DiStefano explains. "We want others to learn from our lessons and what we've done. We want to help other programs improve."

[For more information, contact Elizabeth DiStefano at elizabeth.distefano@stjohn.org.] ■

PA hospitals cut label errors by 37%

9 hospitals target blood specimens

A project designed to analyze labeling errors and devise solutions resulted in a 37% decrease in errors across nine hospitals in Pennsylvania.

From August 2009 through October 2010, the Pennsylvania Patient Safety Authority (PPSA) sponsored a multi-hospital blood specimen labeling collaborative. The PPSA worked with the hospitals to measure blood specimen labeling error rates, document hospital-specific interventions to reduce the labeling error rate, and measure the outcome of the interventions.

Eight acute care hospitals and one rehabilitation hospital participated in the collaborative, says **Megan Shetterly**, RN, MS, patient safety liaison for the Northeast Region of the PPSA. Each hospital assembled a team to participate in the collaborative, and team members included laboratory directors, phlebotomy supervisors, patient safety officers, and risk management, quality and performance improvement, and regulatory compliance personnel. Some of the hospitals used bar coding technology in some areas but not throughout the hospital.

PPSA provided educational sessions about reliable design, just culture, and human factors engineering. Subsequently, each hospital team mapped its blood specimen labeling process, assessed the process for compliance through direct observation, and presented an overview of the processes to the rest of the collaborative participants.

This project was an opportunity for the collaborative participants to identify barriers to labeling compliance that transcended specific care areas and organizations, Shetterly says. Common barriers were those related to technology, communication, education, staffing, workflow, and leadership.

PPSA also trained participants in root cause investigations, and by October 2010 it had collected and analyzed 485 investigations. Facilities reported 520 contributing factors associated with the mislabeling errors. The top three contributing factors were procedures not followed, distractions and interruptions, and unplanned workload increase.

The collaborative participants implemented more than 20 interventions between April and July 2010. There were six major categories of barriers to blood specimen labeling accuracy: technology, communication, education, staffing, workflow, and leadership. The collaborative participants implemented several interventions within these domains to improve specimen labeling accuracy. Overall, there was a 37% statistically significant decrease in blood specimen labeling errors in the collaborative over the 18-month period, Shetterly says.

The PPSA project also involved patients by encouraging them to question caregivers about following proper identification procedures. Patients were given pens as a small gift that might be used and seen often, and signs were posted in rooms with the slogan "Did you ID me?" Shetterly also encourages hospitals to shadow staff doing blood draws and other specimen collection.

"We followed around some of these nurses who were doing the blood collection, and we saw things that the project managers in the hospital didn't see," Shetterly says. "Sometimes it takes a fresh set of eyes. If you're around the same place long enough, you don't notice that cobweb up in the corner anymore." (The full PPSA article, "Reducing Errors in Blood Specimen Labeling," is available online at http://www.patientsafetyauthority.org.) ■

Leapfrog Group to honor role of nurses

In its annual survey, The Leapfrog Group will now honor nurses who demonstrate excellence in the area of patient safety.

"With this addition to our annual survey, Leapfrog is recognizing the vital role nurses play in patient safety and their strong commitment to transparency," according to Leapfrog CEO Leah Binder. "I am constantly finding that the highest performing hospitals, many of Leapfrog's Top Hospitals, have earned the prestigious recognition of Magnet and nurses are the most vocal supporters of making patient safety and quality information transparent. Our employer members value this designation, and its implications for safety, and believe hospitals deserve recognition when they achieve it."

The Magnet Recognition Program was developed by the American Nurses Credentialing Center for hospitals that provide top-notch nursing practices and patient care. ■

EDs taking on the issue of chronic pain

EDs guide patients to appropriate resources

It's a problem that every ED grapples with: A patient comes in complaining of chronic pain and you give him or her a one-time prescription for a powerful narcotic with instructions to seek comprehensive treatment from a primary care provider (PCP).

But the patient keeps coming back to the ED — sometimes as frequently as once or twice a week. And there is often no telling what other EDs or providers the patient has visited for pain medications in the mean time.

How to best meet this patient's needs can present a real quandary for emergency medicine personnel. "The issue has been put in somewhat higher relief as we have seen increases in prescription drug misuse and abuse over the last decade," explains **Knox Todd**, MD, MPH, chairman of the Department of Emergency Medicine at the University of Texas MD Anderson Cancer Center in Houston, TX. "And that is in the face of what many consider to be an unmet need among patients with under-treated pain."

Patients who come to the ED seeking narcotic medications do not necessarily represent a huge number, but they can consume an enormous amount of time and resources, explains **Suzanne Johnson**, DO, FACEP, assistant director of the ED at Alameda Hospital in Alameda, CA, and the chief medical officer of Rational Pain Care, an Oakland, CA-based organization that helps hospitals and EDs devise solutions for dealing with chronic pain in emergency settings.

"These are patients who have a difficult time managing chronic pain in the outpatient setting, so they are really using the ED inappropriately to obtain short-acting narcotics, as well as narcotic prescriptions," says Johnson. "And because these folks often have overlaying psychosocial issues that make dealing with their chronic pain more difficult for them, they can present significant behavioral challenges to us in the ED."

While many EDs have responded to the problem by implementing "no-opioid" policies for patients who visit the ED frequently, this approach rarely works, says Todd. "Those fairly simplistic rules tend to break down pretty quickly. Most EDs that have tried to implement a no-opioid policy have quickly violated that policy, and do so routinely. It doesn't have a lot of lasting value."

However, while there may be no simple solutions to the problem, some EDs are making progress with more robust solutions that connect patients with resources, set up means of communications between providers, and establish clear prescribing policies that all emergency providers follow.

View ED visit as an opportunity

Charles Shufflebarger, MD, chair of emergency medicine at Clarion Health in Indianapolis, IN, has observed an increasing number of patients with chronic pain in the ED over the last several years. "I have responsibility for several EDs, and it is the same pattern in all of them," he says. But just this past October, Shufflebarger and colleagues at Methodist Hospital in Indianapolis began an innovative program aimed at connecting these patients with resources that will help them manage their pain without repeated trips to the ED for medications.

"We worked with our behavioral-health and our care-management staff to develop a multidisciplinary approach so that when patients are identified who have chronic pain, and who have not been on a chronic pain treatment program, we are able to get our care-management staff to coordinate care with their PCPs, as well as our chemical dependency staff," explains Shufflebarger. "We don't deny treatment for pain initially. What we do is use the visit in which we identify the need as an opportunity to give the patient information about our program, and to let them know how strongly we feel it is important for them to follow-up through it."

When a patient with chronic pain first presents to the ED for care, it is the treating physician's job to explain the program and why it would be beneficial. Care-management nurses reinforce this message and provide printed materials that describe the program, explains Shufflebarger. When patients don't have a PCP, the ED staff will find them one and get an appointment set up. "We make sure that the PCP is aware that we are also making a referral to a dependency program for pain management," says Shufflebarger. "Our dependency program provider has agreed to see all of these patients without regard to their insurance or any other considerations."

Care managers will notify the chemical depen-

dency provider when a patient has been referred, and the chemical dependency provider will let the ED know if that patient has failed to schedule a follow-up appointment, says Shufflebarger, noting that patients are given a window of time to connect with both the PCP and the chemical dependency provider.

"If patients haven't followed up, usually within about two weeks, then we are disappointed that they haven't followed through with our referrals and we consider them to be out of compliance with what we require," he says. "Most of those patients will not be treated with controlled substances in the future."

Get all providers in the loop

A key aspect of the program is that all the providers involved with the program have access to care-management notes that are available through the health system's electronic medical record.

"Everyone internally has access, and most of the doctors who are in our system have access to these notes as well," says Shufflebarger. As a result, the care-management notes become a central means of communication, keeping PCPs, ED clinicians, and the chemical dependency provider informed about a patient's progress with the treatment plan.

Just eight months into the program, it is too early to quantify the results, but Shufflebarger says the program has produced moderate success.

"We have examples of patients who are doing well in the dependency program, we have patients who have graduated from the program and are now on pain management without narcotics, and we have many patients who have failed," he says. "We didn't expect that this would be successful for a huge majority of patients."

However, Shufflebarger says program administrators are pleased with the approach because it provides a good opportunity for patients who are open to treatment for their chronic pain to get into a better care plan. "It is true that this is a difficult ailment to treat, but some patients will get better, so if our only approach is 'you can't get your medicines here' we might be missing an opportunity into a better way of treating their pain."

Develop a policy

The ED at Dosher Memorial Hospital in Southport, NC, has also experienced frustration from patients coming in regularly to seek treatment for chronic pain. In fact, as recently as two years ago, it became clear that something needed to be done to address the problem, explains **JoAnn Turzer-Commesso**, RN, the director of emergency services at Dosher. "We kept telling these patients that they needed to go to their PCP for treatment of pain, but it didn't seem to be getting through," she says. "We had some patients coming in here more than 30 times a year, and there were quite a few coming in once or twice a month."

It got to the point where the medical executive committee at the hospital asked ED leaders to investigate the problem and come up with a policy to manage the issue, says Turzer-Commesso, noting that it took six months of regular meetings between ED department leaders and hospital medical executives, and input from risk management, to come up with a working policy.

"We had very long discussions, and we reviewed policies from other hospitals," adds Turzer-Commesso. "The other issue was there had been some deaths in the community related to drugs, so the medical examiner was able to give us some information as well."

Get physician input

The new policy, which was implemented in January of 2010, establishes that the ED physician will determine whether a patient complaining of pain will be treated with narcotics, but it also states that patients with chronic pain should be treated by their PCP, explains Turzer-Commesso. "In most cases, physicians will give these patients non-narcotic medications to treat their pain, and we will refer them back to their PCP," she says. "We also refer some patients to pain clinics, we talk to them about their pain management, and we document this in their chart."

For cases in which patients do not have a PCP, the ED staff will try to connect them with a provider or a health clinic in the area. "We look at each patient individually. If we have a patient who keeps coming back, the physicians look the patient up in a North Carolina registry to see if she or he has been to other places," she says.

When the policy was first implemented, the hospital made sure that it was publicized through local media so that community residents would be aware of the change. In addition, the policy is posted so that patients coming into the ED have an opportunity to review it. As a result, most

patients have been cooperative, and the ED is not as backlogged as it used to be, says Turzer-Commesso.

Volume is slightly down in the ED, although Turzer-Commesso says it is not clear whether the change has to do with the new policy or some other factor.

However, she stresses that much of the drug-seeking behavior has stopped, and many patients who have been referred to pain clinics or other providers for help are making progress. "We know quite a few patients who have come clean," she says.

Furthermore, the ED physicians — who had ample opportunity to review the policy and offer their input — have reported no difficulties in working under the new guidelines. "At least they have something to lean back on now," says Turzer-Commesso. "They can [tell patients] that we have this policy."

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Bedside barcodes reduce pharm errors

Barcoded wristbands can greatly reduce the opportunity for patient identification errors, says **David Grant**, RPh, MBA, vice president of pharmacy and clinical process improvement at Summit Health in Chambersburg, PA.

The barcoded wrist band is placed on the patient at admission and then is used for all specimen collection and medication administration, Grant says. Summit Health first began using the barcode technology about six years ago, when about 15% of U.S. hospitals were using it, he says. Now that figure is closer to 35%, he says.

Summit's barcode system is used in the pharmacy when the medication is dispensed and also at the bedside before it is administered.

"The nurse uses a handheld scanner to read the barcode, and if they have the right patient, they are allowed to proceed with administering the medication," he says. "If they don't have the correct patient, it closes the medication administration record and notifies them that they don't have the right patient."

Staff responded well

As a result of the barcode technology, "wrong patient administration errors have all but disappeared," Grant says. That success eliminates about 30% of all medication errors, he says, because administration errors make up about 15%, dispensing errors account for another 15%, and transcription errors result in about half of all medication errors.

Staff members have responded well to the new system, with more experienced nurses saying they would never want to go back to paper medication orders, Grant says. Summit spent about $1 million on the hardware and other infrastructure necessary for the barcode system. Planning took about two years, and the new system was rolled out over eight months.

"It's been a resounding success for us and we wouldn't go back," he says. ■

COMING IN FUTURE MONTHS

- Patient and Family Advisory Council sets quality and safety goals
- Can hospitalists improve quality and decrease costs at the same time?
- IOM addresses essential preventive health services for women

Reduce ID errors with 24/7 phlebotomy

There are ways to minimize labeling errors. Top strategies include bar coding technology, firm policies and procedures, and accounting for the human factors that can prompt errors. Research also suggests that establishing a 24-hour, seven-days-a-week phlebotomy service can reduce errors by leaving blood draws to the people best trained and focused on the task.

Ana K. Stankovic, MD, PhD, MSPH, vice president of medical and scientific affairs and clinical operations with BD Diagnostics, based in Franklin Lakes, NJ, conducted research that involved reviewing more than 3.3 million specimen labels from 147 laboratories.[1] Labeling errors were identified at a rate of 0.92 per 1,000 labels. Two variables were statistically associated with lower labeling error rates: laboratories with current, ongoing quality monitors for specimen identification; and institutions with 24/7 phlebotomy services for inpatients.

Most institutions had written policies for specimen labeling at the bedside or in outpatient phlebotomy areas (96% and 98%, respectively). Stankovic and her colleagues concluded that establishing quality metrics for specimen labeling and deploying 24/7 phlebotomy operations might contribute to improving the accuracy of specimen labeling for the clinical laboratory.

"Dedicated phlebotomists are much better because they are better trained and they are not distracted by needing to do a hundred other things," Stankovic says. "We see hospitals transitioning back to dedicated phlebotomists because they are finding that the front-end costs are offset by the back-end costs of errors, redraws, and other problems."

In addition, patient specimens should include two distinct identifiers, and one should be a number, Stankovic says. For example, the label can include the patient's name and birth date, or name and Social Security number. Using both will help eliminate confusion when patients have similar names, she says.

REFERENCE

1. Wagar EA, Stankovic AK, Raab S, et al. Specimen labeling errors: A Q-probes analysis of 147 clinical laboratories. *Arch Pathol Lab Med* 2008; 132:1,617-1,622. ■