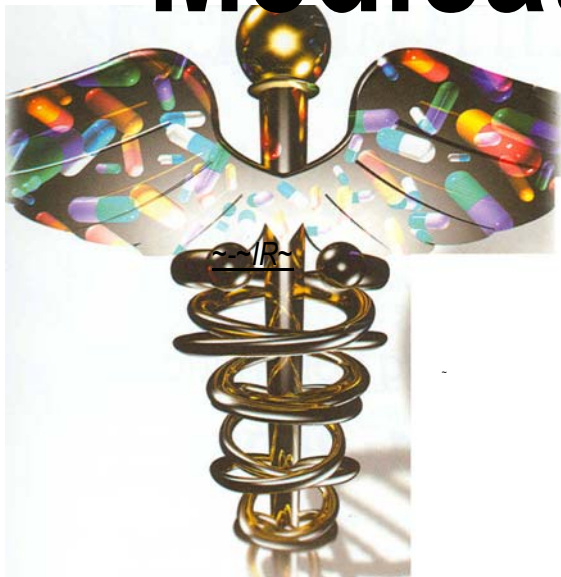




Concept Pieces

Medication Safety & Education



Why “Just Trust Me” Doesn't Fly

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Ancedotes and reports of widespread medication errors strike fear in employers, payers and patients (collectively "purchasers"). Drugs that cause problems instead of solving them are terrifying to the same payers. Who is in charge? Where is the command and control system for managing risk (i.e., errors)? Who is watching out for the patient when it comes to drugs, adverse effects, and medication errors? The obvious answer is... the profession that hands out the medications, educates, has the greatest well of medication knowledge, and has the greatest amount of face-time with patients. So...

What do employers, payers, and patients want from pharmacy and pharmacists? This is a different perspective than what pharmacists believe they have to deliver. Separate from some assurance of effectiveness and cost, is a need for insurance for risk. The fears of medication errors and adverse drug effects are manifestations of an unknown risk and the lack of knowledge (maybe helplessness) for any recourse. Who else would patients turn to but their physicians and pharmacists? Furthermore, employers and health plans that pay for benefit services look to the healthcare system in general for some type of risk management. This may be as simple as monitoring and surveillance to minimize adverse effects. It may be assurances that the system has built in controls for minimizing medication errors. At the heart of the concern of payers is that the system includes risk management guarantees similar to the guarantees provided for retail products and services.

The evidence is everywhere that the health system that we should receive is not what we get. Employers and payers have developed internal processes for the last sixty years that focus on minimizing errors. Yet, reports like the Institute of Medicine's "To Err is Human: Building a Safer Health System" indicate that a similar emphasis is not

present in healthcare. Medication errors are singled out as particularly troubling, because they are symptoms of a process that can be fixed.

The statement, "just trust me" doesn't work in this environment. How do payers approach the quality problem, which is evidenced by medication errors? They look to quality improvement techniques that make them more competitive and for a decrease in errors overall. They have a sixty-year history of such efforts that began with W. Edwards Deming, who taught the Japanese after World War II to measure, focus on quality improvement, and reduce errors by doing things right the first time. The success of Japanese companies such as Toyota and Sony motivated American firms to champion total quality improvement (TQM), continuous quality improvement (CQI) and quality circles. Companies such as Westinghouse, Ford Motor Co., and Philips Semiconductors lead the way. Hospitals later endorsed quality improvement to decrease errors, but these efforts were sidelined when prospective payment leads hospitals to focus on cost cutting.

The re-emergence of an emphasis on quality in healthcare was hampered by the concern that quality could not be measured in medicine. This notion was dismissed by quality gurus like Donald Berwick, MD of the Institute for Healthcare Improvement. Employers further challenged the healthcare system to improve through coalitions such

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as the National Quality Forum (NQF) and the Leapfrog Group. The private sector was complemented by federal government agencies such as Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) that challenged hospitals to implement quality improvement programs. The Veterans Administration (VA), SSM Health Care in St. Louis, Henry Ford Health System and other hospital systems across the country answered the quality appeal. Recently a coalition of hospital and health care organizations launched the *Surgical Care Improvement Project (SCIP)*. The goal of the SCIP is to have every hospital in the United States, offering surgical services to monitor and report performance by one of four sets of clinical quality measures by the end of 2006. The measures include medication-related measures and surgical infection rates. The quality goal is to reduce surgical complication rates by 25% by 2010.

The ambulatory sector is not immune to the demand for quality improvement. The size of the patient population and the number of medical and pharmacy encounters in the ambulatory sector dwarfs the few patients hospitalized annually in the United States. The NQF has recently issued a series of thirty-six quality performance measures for outpatient care by physicians that was developed through a consensus of more than 260 groups including providers, consumers, purchasers, federal agencies, professional organizations, and research and quality improvement organizations. According to the NQF, the standards represent evidence-based quality measures for structure, process and outcomes. The ultimate goal is to link these quality indicators to a pay-for-performance model (P4P) for physicians, outpatient medical care, and hospitals.

The federal government, through Medicare, is also taking up the quality imperative. A recent study by the Commonwealth Fund indicated that Medicare has succeeded in providing access to basic care for seniors, but it has not used its purchasing power to improve the quality of care. With a \$300B annual budget tied to a trust fund that

is predicted to be bankrupt by 2019, Medicare has announced a 4.3% cut in physician reimbursements in 2006. The counter balance to the physician pay cut is a proposal to pay bonuses (i.e., P4P) for those physicians to deliver better care to seniors. Medicare expects to establish quality standards by 2009 for the P4P.

Pharmacists are in position to identify safety problems, educate patients to avoid high-risk situations, measure the outcomes one patient at a time, and keep educating to improve on the outcomes. This requires an industrial process type of mindset that is continually trained into the system of dispensing and treating patients. The focus is less on formalized TQM or CQI programs, and more on improving customer (or patient) satisfaction. The key is, that once you start, you can't stop. The process has to become ingrained in the delivery of care. This is, also, a prudent business practice.

The demand for quality improvement and its impact on safety for patients is here and it isn't going away. Medications are a lightning rod for improvement, because literally everyone takes them. Medication errors that could easily happen to anyone is the smoking gun to patients and purchasers. So what are pharmacists to do? They can sit on the sidelines and allow others to develop the standard for quality care in drug therapy management; or they can lead the charge for medication safety. The purchasers have spoken; they have said what they want. The safety and quality imperative is to provide it to them!

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