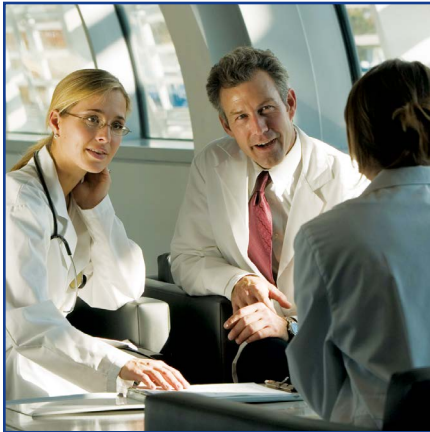


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Care Processes

Effective Implementation of Enhanced Recovery Pathway Programs: The Key to Disseminating Evidence into Practice

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In this issue of *The Joint Commission Journal on Quality and Patient Safety*, Christopher Wu and colleagues provide an intriguing summary and unique perspective on their experiences with implementation of an enhanced recovery pathway (ERP) within the Department of Anesthesiology at The Johns Hopkins Hospital.¹ As fast-track surgery has evolved into multidisciplinary care initiatives that require coordination between key stakeholders from surgery, anesthesiology, and nursing, and that leverage large data stores from integrated electronic health records (EHRs), an improvement in the perioperative care delivery model has taken place. Despite recent debate on the clinical efficacy of some components of ERPs, there is now strong evidence that effective implementation of these comprehensive care initiatives is associated with enhanced value of care, as realized through decreased perioperative morbidity, decreased hospital length of stay, and improved patient satisfaction.^{2,3}

The commonplace observation made about medical care in general, as recently articulated by Urbach and Baxter, that “the immediate challenge to improving the quality of surgical care is not discovering new knowledge, but rather how to integrate what we already know into practice,”^{4(p. 1402)} is very true for ERPs. Although the pathway itself will vary from institution to institution, the essential elements will be similar. There is no “secret recipe,” but each hospital should review the evidence and design a care pathway that will work in its own setting. Importantly, an ERP will also standardize practice and facilitate cooperation between specialties and therefore improve the quality of care that is delivered, while simultaneously improving patient safety. The real challenge with ERPs, as with other innovative and comprehensive care initiatives, is the complex process of implementation. Many factors are critical to success, such as senior clinician and executive leadership commitment, as well as available funding and personnel resources, the presence of clinical champions, and the local clinical and operational context and its readiness for change.

As Wu et al. report, the clinical and economic benefits provided by an ERP can only be truly realized through a deliberate and iterative change management process. In the study,

operationalizing the ERP took more than six months from planning to implementation, which the authors considered to be a “fast pace.” This is consistent with our experience. The authors also noted that they struggled with consistent anesthesiology staffing inside the operating room, the establishment of autonomy for the Acute Pain Service to manage postoperative analgesia, supply-chain issues with pharmacy, and work-flow integration with the existing EHR. These are concrete examples of how the structure of a hospital system can hinder the clinical efficacy and cost-effectiveness of ERPs immediately following implementation. As we look into the future, it is our belief that site-specific refinement of ERPs will be absolutely critical to realizing their full potential clinical and economic benefit.

The paradigm shift in the perioperative care delivery model created by ERPs comes at a critical time for health care in the United States: The language used in the Affordable Care Act (ACA)⁵ was calculated to create an environment that cultivates change by realigning incentive structures with meaningful clinical and financial outcomes. Perioperative value delivery and, consequently, reimbursement models in the United States, will soon be measured in terms of exceptional clinical outcomes, superior patient satisfaction, and cost-effectiveness.^{6,7} In fact, we are currently observing an erosion of the existing fee-for-service model by a system that rewards valuable care delivered in a financially responsible manner.⁷ Therefore, in the ACA era, the perioperative value equation must be redefined if the fiscal stability of the care delivery model is to be preserved. ERPs such as the one described by Wu et al. vividly illustrate a potential route to enhancement of this value proposition for surgeons, anesthesiologists, and nurses alike. For example, the authors achieved a 45% reduction in length of stay and improvement in patient satisfaction from the 37th to greater than the 97th percentile among colorectal surgery patients after six months of exposure to all ERP elements. Reduction in length of stay has been conclusively shown to reduce total cost of care in several surgical populations.^{3,8,9} Furthermore, in a recent systematic review of the economics of ERPs for colorectal surgery, Lee et al. stated that, of 10 studies conducted in the United States and Europe

between 1997 and 2012, 8 reported reductions in total costs following implementation of the ERP, including all 4 of the sites in the United States.¹⁰ These data are clearly supported by the results reported by Wu and colleagues, who, importantly, go one step further to conclusively illustrate *how* these benefits can be realized. What is needed now is improved data collection and reporting on how ERPs can be implemented across a wide range of hospital types in a more systematic way so that these clinical and economic benefits can be achieved consistently on the international stage.

To develop an innovative way to improve the value of the perioperative care delivery model, we must focus on ways to enhance patient safety, improve patient satisfaction, and decrease overall health care utilization. As illustrated in the article by Wu et al., an ERP can reduce hospital length of stay and improve patient satisfaction, which improves the perioperative value proposition by enhancing outcomes and reducing the cost required to deliver those outcomes. Importantly, the clinical and economic benefits highlighted by the authors are supported by a growing body of literature that describes the clinical efficacy and cost effectiveness of ERPs in both the United States and Europe. Furthermore, the authors should be applauded for their effort to describe the change management process necessary to implement their ERP, as this is a critical yet often overlooked component of ERPs in existing literature. We believe that it will be the standardization of this change management process that creates the activation energy necessary to truly disrupt the care delivery model during the age of health care reform. **1**

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