

The quality imperative:

New tools and expanded responsibilities for surgeons

by

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It's difficult for many of us in practice to comprehend the speed and intensity of the health care quality measurement and public reporting movements. The combined pressures of increased expenditures, soaring medical liability premiums, and patients' perceived threats of harm have created an overarching imperative to improve quality, control costs, and help patients become better health care "consumers." Payors and consumer activists are insisting that physicians and other providers become more accountable for the quality of medical care they deliver.

In response to these demands, policymakers are seeking ways to show that access to high-quality, affordable care is possible. This year they hope to make it easier for consumers to access public quality reports for nursing homes and home health care. These reports allow patients to compare performance measures of facilities and make educated decisions about where to seek care. However, the challenge lies in defining what works over time and when there are fewer financial resources and higher patient expectations.

A surgical tradition

The College has been at the forefront of the quality improvement movement since 1913, when it was founded to set patient care standards and uphold the enduring ethical principle of "first do no harm." Ernest A. Codman, MD, FACS, though shunned in his day for his insistence on tracking outcomes, proved that surgery could measure and police itself. Surgeons were the first clinicians to talk directly to patients about cancer treatment options in a consumer publication, such as *Ladies' Home Journal*. In 1915, the College hosted forums throughout the U.S. to talk about early detection and to identify cancer treatments that helped increase survival rates. Then in the late 1920s surgeons once again became patient advocates, insisting that hospitals and surgical suites meet acceptable standards of care. This effort set the foundation for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Since the early 1940s Fellows have developed systems to improve our ability to monitor and identify effective treatments for cancer. Then in the late 1960s, as it became clear that early intervention for trauma patients within "the golden hour" meant a higher survival rate, the

College worked to certify and train members of state networks. Ever since, the College has been committed to tracking what worked best for care and survival of the trauma patient. Fueled with the data, the College has helped develop responsive, statewide networks to secure the best quality of trauma care for our patients at every step of the emergency response process. Our vision for the future includes further analysis and expansion of two benchmarking tools—the National Cancer Data Base and the National Trauma Data Bank™—so that patients and clinicians can identify areas for improvement, as well as set best practices.

Drivers of the movement

In the last decade, a convergence of factors has driven health care policy. In 1999, the Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, challenged the entire American health system to develop a better way to protect lives. Subsequent reports from the IOM and purchasers have caused a ripple effect, increasing the cry for a more transparent quality improvement and public reporting system. The continued drumbeat about “risks” that exist within the system, coupled with increased consumer expectations about good outcomes, has stunned medicine and may have undermined the confidence that our patients have in our judgment. What caused this shift in the patient care landscape, and what is the College doing about it?

At the end of the last decade it became increasingly clear to policymakers that previous attempts at reform had failed. Managed care was unable, over time, to both control costs and assure quality. The statewide health plan implemented in Oregon suggested that health care services and funding could and should be prioritized, but that system, too, failed to control costs.

These and other health care reform efforts of the early 1990s were frustrated by the inability to retrieve useful outcomes data from health care information technology systems designed to account for claims. Effective use of resources, we found, depended on a more well-informed and engaged patient, as well as the ability to stay current with fast-paced innovation, develop thoughtful treatment plans, effectively manage a practice, and so on.

New expectations

Today, payors are asking the medical professions to be more forthcoming with data, measuring their performance and ultimately being held accountable for the quality of care provided to their beneficiaries. Accountability means something different to each stakeholder. Many physicians have been surprised by the tacit challenge to their commitment to providing the highest quality care. It has become increasingly clear that few policymakers and consumers understand the rigorous requirements for board certification or membership in many professional organizations. Fewer still understand the rigor required and the ongoing education efforts provided by Fellowship in the College, or the scrutiny peers offer on our caseload and experiences during surgical services reviews and in morbidity and mortality conferences.

Instead, purchasers are reacting to the steady climb in health care costs. Once again, they are looking at ways to “buy better.” Their position: set standards for care, remove wasted efforts and cost from the system, direct patients to the known high-quality providers, and apply volume-based purchasing theories. The expected result: better quality for patients and lower costs for purchasers. While some of these principles have worked well to improve efficiencies on the assembly line, patient care doesn’t always lend itself to following specific standards. Patients’ needs, conditions, and circumstances are too varied.

The idea of measuring and reporting quality makes good sense. But defining and implementing the “ideal” quality principles have become increasingly difficult. Medical standards and practice have become more sophisticated in less time. The half-life or turnover of medical information and technology has compressed to four years. More patients survive longer, and in the end require more expensive care. The complexity of care, the proliferation of lifesaving technology, and the scarcity of our resources come together in what seems to be a “value” collision course. Yet, purchasers have not been forthcoming in offering to pay for the additional data collection and analysis. Hospitals burdened with providing more than 30 performance measures want surgery to define three or four comprehensive (and timeless) measures of quality to track over time. It becomes even more

important for all the stakeholders to sit down and determine what will provide the highest value for our society and, ultimately, what it is worth to each of us.

Culling the pearls

To achieve some consensus on what constitutes quality, the country's largest purchaser of health care services, the Centers for Medicare & Medicaid Services (CMS) is encouraging an informed discussion among all the stakeholders—consumers, payors, health service researchers, physicians, and other providers.

The National Quality Forum (NQF), a private sector offshoot of the national health care reform efforts, was established to encourage that discussion of the overarching quality standards in health care with all perspectives at the table. NQF's mission is to develop consensus on what medical insiders understand to be quality care and to translate that information to the public. The difficulty has been in defining quality and determining what sort of comparative information is useful to patients as they select providers of elective care. Perhaps one of the fundamental sticking points in this quality discussion has been the process of collecting meaningful data, without burdening the health system any further. To some activists, bad data are better than no data. Based on our 90-year history of assuring quality, the College is of the contrary opinion that only decisions based on sound data are in the best interests of the patient.

Many clinicians, however, have been frustrated by the pressing urgency to report data that aren't reliable. It is not that they are unwilling to come forward with that information, but their training and commitment, aimed at ensuring that patients have accurate and meaningful data, means a dedication to fully validating any procedures that will affect their patient. So, while each of us knows there is a relationship between quality, safety, and cost, it has been difficult to retool the delivery system and to get the data that will help us uncover wasted resources and to identify obstacles to providing the most effective therapies and systems.

It doesn't have to be such a conundrum. Surgery has never lost sight of our fundamental responsibility to be the patient's quality care advocate. In addition to ongoing work in cancer and trauma, last year the College received a \$5.2 million grant

from the Agency for Healthcare Research and Quality (AHRQ) to further validate the Department of Veterans Affairs (VA) National Surgical Quality Improvement Program (NSQIP) in 14 private sector hospitals.

NSQIP is an exciting, risk-adjusted, surgical outcomes "registry" and benchmarking effort that is credited with improving mortality rates by 27 percent and the morbidity of cases by 47 percent in 122 VA hospitals. This system has been at work in the VA since 1996 and provides pre-, peri-, and postoperative observations of all surgical patients and conditions for up to 30 days after a procedure.¹ Shukri Khuri, MD, FACS, and the many surgeons who designed the system realized that it needed to provide risk- and complexity-adjusted outcomes that could be compared to national averages. Specially trained registered nurses, biostatisticians, and surgeons collect and analyze the data, which are entered into a Web-based collection and benchmarking system. The resulting sets are risk-adjusted and compared with information in a database of more than 900,000 patients.²

Once the information is processed, the surgeon and the surgical service are able to compare their observed versus actual outcomes experience (o/e) with the national average and comparable hospitals. Additional research on the NSQIP system suggests that the national database offers us the information necessary to identify outliers. It also suggests that when volume without risk adjustment is used as an indicator of quality of care, in 60 percent of the cases the patient could have been sent to a lower performing facility.³ In addition, comparison with national data sets serves to highlight costly practices and may be used to predict the likelihood of difficulties for particular patient profiles and procedures.

The challenge for the College and the VA was to show that the system worked with a non-static population. The three initial test sites—Virginia, Kentucky, and Emory University in Atlanta, GA, showed that the system worked with populations not represented in the VA.³ As part of the grant, the College has engaged 11 additional private sector centers in Michigan, Missouri (St. Louis University and Washington Universities), Utah, Florida, California (University of California, San Francisco), Maryland, New York (Columbia and Cornell Universities) and Massachusetts (Massa-

chusetts General Hospital) to put NSQIP to the test. After one year, the investigators are pleased with the tests of the program's risk adjustment, data collection, and benchmarking capabilities in hospitals that serve a broader population than typically reflected in the VA systems. While preliminary results will be reported this spring, principal investigator Dr. Khuri and the site investigators believe that this model could provide a data collection system for the entire surgical profession. This kind of system has the prospect of serving, in very much the same way as the tumor registry program that the Commission on Cancer of the College coordinates with the American Cancer Society, as a comparative quality-improvement database. The investigators, while concentrating on providing meaningful data to surgeons, understand the need to explore how the public might use the information to assess the strengths of a surgical service. National leaders in the health care measurement and public reporting arenas, as well as large health plans, are very interested in NSQIP, and we are currently pursuing opportunities to validate it further.


A long-term situation

In the meantime, it is essential that surgeons understand that the public reporting movement will not go away. Purchasers are demanding greater transparency of what is meaningful and why in health care. They want to understand the data that medical insiders consider when evaluating care. The College's Division of Research and Optimal patient care is committed to developing promising improvement systems and expanding the use of current College data sets.

To set a well-informed course for the measurement and reporting of quality surgical care, the College will be hosting a meeting of the leadership of the Surgical Specialty Societies in March. The group will hear from all the stakeholders involved in this national effort and hopes to develop principles that will guide surgery's efforts in the legislative and regulatory arenas. While no bills are pending in Congress, the College's Health Policy Steering Committee's workgroup on quality and patient safety is mindful of the intense pressure to develop report cards, as well as workable and meaningful standards that the public may use to evalu-

ate and purchase health care. CMS has been charged with finding meaningful standards that can be implemented within the calendar year. AHRQ will be releasing the National Quality Healthcare Report this fall. The subcommittee will continue to assess, monitor, and advocate on behalf of surgeons in this arena. In the months to come, we hope to continue our role by convening several work groups to address the issue of what information is meaningful for surgeons to report and for their patients to use in evaluating quality of surgical care.

Despite the upheaval in health care, the College is prepared to maintain its historical role as the patient's quality advocate. We look forward to the results of the NSQIP trials in these health systems. We also hope that in the months ahead, more surgeons will help legislators and regulators understand what it will take to bridge that gap between what we know is clinically valuable and what our patients want to know about the quality of the care they receive.

For more information about the College's continuing efforts to measure quality of patient care and application of standards, please go to <http://www.facs.org/oeps/otherendeavors.html>. For more information about the College's work translating quality measurement to policymakers, contact lamar.mcginnis@cancer.org or bcebuhar@facs.org. If you would like to learn more about NSQIP and other quality of care initiatives, contact the Division of Research and Optimal Patient Care or Karen Richards in the Office of Evidence-Based Surgery, krichard@facs.org. 

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