

From my perspective

When shopping for a new car or choosing the right university for our children, many of us feel compelled to read publications that rank the quality and performance of these high-ticket items. Ratings for most consumer goods and services have been widely available to the public for decades. Not so with regard to health care. That situation is about to change.

The first signal of movement in this area was seen when the Centers for Medicare & Medicaid Services indicated to the public that it would start evaluating nursing homes and then make its findings available to the public. Additionally, several private-sector coalitions that represent the interests of employers who offer health care benefits to their workers are seeking data that will assist them in choosing cost-effective providers. And, as patients become more responsible for their own health care decisions, they are looking for quality indicators that will allow them to make informed choices.

One result of the evolving movement toward rating the quality and performance of health care providers is the emergence of a new lexicon to describe various activities and concepts. Terms such as value-based medical purchasing, consumer-driven health, care-focused purchasing, pay for performance, and “score cards” for health care professionals and providers are becoming commonly used phrases in discussions about our health care system.

Why now?

An obvious question is, why has it taken so long for health care to be evaluated based on hospital and surgical outcomes? One reason is that it is extremely difficult to objectively determine the quality of care provided using the existing administrative and insurance data, all of which have inherent qualitative defects. In moving more deeply into this controversial arena, we must all realize that any attempts to evaluate hospital and surgical outcomes must employ and analyze data that are science-based and risk adjusted.

An article in last month's *Journal of the American College of Surgeons* points out that measuring the quality of surgical care is a complicated process that requires different data than this profession has typically analyzed during morbidity and



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mortality conferences. Benchmarks that must be used in evaluating health care to arrive at the sort of rankings that are now in demand include the volume of cases, processes of care, and outcomes. For example, as the authors of the article note, some procedures are performed relatively infrequently but have very high risks associated with them, while the opposite is true for other operations.* In other words, we need to look at both the outcome and the circumstance surrounding the procedure.

In the past, some surgeons and institutions have done an excellent job of evaluating performance indicators and surgical outcomes. For example, since 1987, six New England hospitals have main-

*Birkmeyer JD, Dimick JB, Birkmeyer NJ: Measuring the quality of surgical care: Structure, process, or outcomes? *J Am Coll Surg*. 198(4):626-632, 2004.

tained a clinical registry on their performance of coronary artery bypass graft and other cardiac procedures. In addition, the Society of Thoracic Surgeons has a large database that tracks data on operations performed by its heart surgeons, and several states—including Pennsylvania and those in New England—have measured outcomes in cardiothoracic surgery.

Likewise, the transplant community, as mandated by the federal government, has effectively used outcomes to evaluate the quality of care in this field. Additionally, many individual surgeons and institutions have developed and maintained their own databases in an effort to monitor their outcomes.

The shortcoming of all these repositories, however, is that they focus only on specific operations or specific disease processes. Additionally, the vast majority of small group and solo practices have lacked the resources needed to adequately assess their level of performance and quality.

The College's role

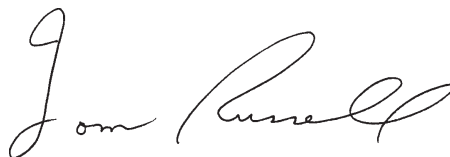
The American College of Surgeons is actively pursuing efforts to help surgeons in all specialties to better meet the imminent demand for quality and performance indicators. Through a grant from the Agency for Healthcare Research and Quality, the College is taking the National Surgical Quality Improvement Program developed by the U.S. Department of Veterans Affairs into the private sector and is demonstrating its validity in assessing surgical outcome in a risk-adjusted way. We will be marketing this program to private hospitals to assist them in their efforts to compare their outcomes with those of other institutions.

Concomitantly, our Committee on Informatics and the Division of Education's Task Force on Systems-Based Practice are developing programs that will allow surgeons to track or log their cases on their personal computers or hand-held devices. These tools will enable practicing surgeons to assess their scope of practice and short- and long-term outcomes.

We are also working with other organizations to evaluate best practices, including the American Medical Association's Physician Consortium for Performance Improvement, the National Quality Forum, and the Joint Commission on Accreditation of Healthcare Organizations.

As a profession, we need to look to the future and continually ask ourselves whether we can find a better way to deliver surgical care. Clearly, we have yet to uncover the best treatment for many disease processes. The clinical trials conducted through the American College of Surgeons Oncology Group and the College's Division of Research and Optimal Patient Care will help us to determine how we can more effectively treat cancer, hernias, and other surgical problems and conditions. These discoveries ultimately may reduce the variability in the performance and outcome of procedures across the spectrum of surgical care.

These are changing times, and surgeons can no longer afford to put their heads in the sand and deny that the public and the government intend to hold us to a higher level of accountability. I urge all Fellows to learn about the new reporting and monitoring systems and to get involved in efforts to ensure that quality measurements are based on scientific evidence.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.