

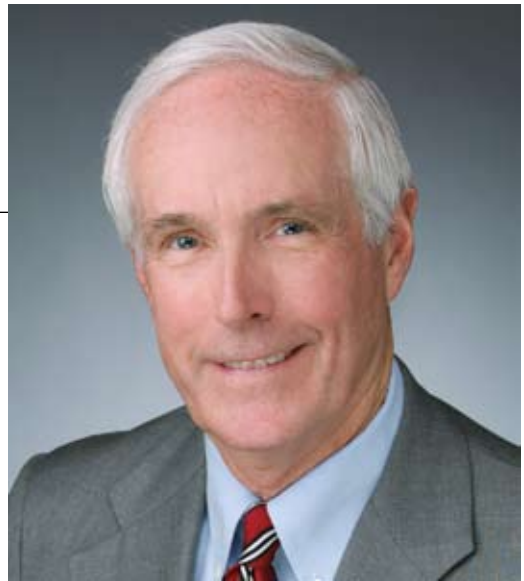
From my perspective

As noted previously in this column, the American College of Surgeons actively participates in a number of groups that are attempting to develop and promulgate quality measures. Given the College's ongoing commitment to promoting standards that lead to safe, high-quality surgical care, we have a professional obligation to assist in generating these metrics of care. And, because the government and other payors are seriously considering how these measurements might be used to determine physician payment, we view our involvement in these efforts as paramount to ensuring that our members receive equitable reimbursement for the services they provide. Whatever one may think of pay for performance, the reality is that ultimately outcomes and reimbursement are going to be linked, and we would be foolish to allow this formula to develop without our input.

Players and process

Key panels involved in vetting quality measures include the American Medical Association Physician Consortium for Performance Improvement (AMA PCPI), the National Quality Forum (NQF), and the AQA (formerly the Ambulatory care Quality Alliance). In this process, ideally, medical organizations, such as the College, present evidence-based clinical guidelines to the AMA PCPI. Once this body has approved the standards, they are submitted to the NQF for consensus-based endorsement and to attain national recognition. The AQA then works with physician organizations, the Centers for Medicare & Medicaid Services (CMS), employers, and health insurers to introduce the measures into the marketplace.

The ultimate objective of this process is to ar-



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rive at a common set of widely accepted measures so that the data may be aggregated and shared for purposes of quality enhancement and public reporting and, eventually, pay for performance. In other words, it is likely that these groups are writing the libretto for the next health care system, determining how care will be delivered and how physicians and other providers will be evaluated and paid.

In addition to playing an active role in all of these consortia and their surgery-related workgroups, the College has formed the Surgical Quality Alliance (SQA). This panel comprises representatives of approximately two dozen surgical specialty societies and is dedicated to ensuring that quality measures account for the unique nature of surgery.

Progress through collaboration

All of these coalitions are making progress in carrying out their missions, and I am pleased to say that the various members are listening to each others' concerns. For example, ACS health policy staff and I recently attended an AQA meeting in Washington, DC. Participating in this program were a host of stakeholders, including employers, the government, insurers, medical organizations, and consumers. As Janet Corrigan, PhD, MBA—president and chief executive officer of the NQF—recently observed, the quality landscape is densely populated.

The fact that such diverse constituents have come together to examine the problems inherent in the existing system and to work together to build a better one is refreshing on an idealistic plane. On a more practical level, however, it also demonstrates that we all realize the relevance of seizing this opportunity to create a more accessible, quality-driven system.

The word is out: Unless we can come together and solve some of these issues, others will be more than happy to do it for us in a way that satisfies their own interests. Indeed, we might find ourselves in another situation like the one that brought us managed care, with business-people rather than health care professionals and patients deciding how medical services are delivered. Some firms already are venturing into what they call care-focused purchasing, which suggests how employers and payors can be certain that they are getting real value for their health care dollar.

It is not enough to simply have a seat at the negotiating table. To truly contribute to this potentially historic sea change, we need to be able to offer recommendations that are supported with scientifically valid data. Opinions are al-

ways controvertible. Facts are solid and indisputable. Therefore, the guidelines and protocols that we develop must be evidence-based, measure a sizable section of the physician population that will be using them, be risk-adjusted, and indicate who will be responsible for ensuring their implementation. It is for this reason that the College has worked so hard to develop the ACS National Surgical Quality Improvement Project and to expand the National Cancer Data Base and the National Trauma Data Bank[®].

Developments

We also anticipate that the SQA will be instrumental in bringing surgery's perspective to the AQA. During the AQA meeting, the alliance approved the following six measures that the College brought forth on behalf of surgery and the SQA: (1) place order for timely administration of prophylactic antibiotics; (2) timely delivery of prophylactic antibiotics; (3) selection of appropriate cephalosporin for antibiotic prophylaxis; (4) discontinuation of prophylactic antibiotics within 24 hours (noncardiac); (5) discontinuation of prophylactic antibiotics within 48 hours (cardiac); and (6) place order for venous thromboembolism prophylaxis.

One would anticipate that competent surgeons already carry out these activities almost reflexively. However, because they are such necessary steps toward avoiding infection, we believe they represent a good starting point. Our primary objective at this time is to determine what is best for patients and how to avert trouble at the "sharp end of care."

In addition, the AQA approved quality measures drawn from assessments of dermatology, rheumatology/clinical endocrinology, ophthalmology, neurology/radiology, orthopaedics, and consumer issues.

Other highlights of the meeting included reports from the AQA's workgroups. One concern raised during these discussions was the cost of care. Employers and third-party payors in particular are demanding greater disclosure and transparency in billing. They want to know the value of the care provided to individuals who are covered under their health plans. Some participants believe that if physicians and other providers are unable to supply this information and fulfill this need, policymakers will choose to implement a single-payor system, giving the government and insurance carriers greater control over spending.

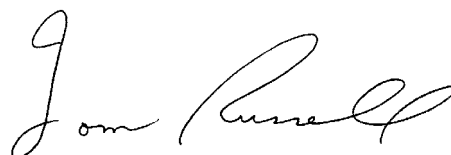
Another concept discussed during the workgroup presentations was the "harmonization" of quality measures. That is to say, the AQA wants to start looking at how the metrics for one condition can be aligned with measures for other diseases. For example, the harmonization workgroup is considering aligning diabetes metrics with those for coronary artery disease. Undoubtedly, such efforts will need to be developed in the future, but I believe they signal the desire for greater collaboration across all specialties.

Possibilities

Given all these objectives, it would seem likely that the new system will focus on two overriding concerns: positive outcomes and transparency with regard to cost. These are the two factors that we need to use as guideposts in determining our input into value-based purchasing.

Furthermore, I believe that surgery is in a better position to measure outcomes and report billing because we deliver services on an episodic basis. Other specialties provide care across a broader continuum in which it may take years to determine the outcome and certain costs may be hidden.

The American College of Surgeons intends to remain actively involved in all programs that are centered on identifying the factors that lead to high performance and quality improvement. We know this movement is too important in determining the future of patient care to allow other special interests to write the script.



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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.