



SQA

THE ACS SURGICAL QUALITY ALLIANCE:

*Specialty societies
improving quality
for the surgical patient*

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Since the Institute of Medicine's report, *To Err is Human*,* was published in 1999, there has been a detectable shift toward improving the quality of health care through a variety of new initiatives, such as public reporting and pay for performance. Our nation's health care system suffers from gaps in consistent care, geographic cost and quality variance, and inappropriate use of procedures and technologies, resulting in escalating costs. These breakdowns affect all entities in the system, and consequently, all health care stakeholders are taking a closer look at the means for solving these challenges. Indeed, a multistakeholder community of purchasers, payors, providers, and patients has united the efforts of these groups to combine quality improvement with cost savings.

Many private insurers, as well as the Centers for Medicare & Medicaid Services (CMS), have developed programs to measure and report on health care providers. CMS Hospital Compare, a

*Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Committee on Quality of Health Care in American, Institute of Medicine. Washington, DC: National Academy Press; 2000.

Web-based tool that allows consumers to view ratings of U.S. hospitals, is a likely template for future physician-level reporting by CMS. Private insurers have taken a number of different approaches to physician accountability. Some health plans merely present their enrollees with the performance data, whereas other plans actively direct consumers by charging smaller copayments for physicians they consider “high quality” or “efficient” or by restricting physician participation in their networks based on performance.

In addition to insurers, many coalitions have formed to collect and disseminate health care data in an effort to inform consumer choice. Both the Wisconsin Collaborative for Healthcare Quality and the Massachusetts Health Quality Partners are community-based coalitions trying to increase transparency in health care and encourage quality improvement. With internal quality improvement and cost reduction as the end goals, most of these coalitions believe that change can only be achieved through public reporting of performance and cost data.

The Surgical Quality Alliance (SQA) is sponsored by the American College of Surgeons and chaired by a Fellow (this article’s co-author). The SQA seeks to bring surgical specialties and anesthesiology together to participate in all aspects of quality improvement for the surgical patient. (A list of SQA member organizations can be found in the sidebar on this page.) Participating surgical societies have agreed that if physician performance is going to be measured in the current environment, surgery should participate in defining which measures truly evaluate the quality of surgical care and determining how measures should be attributed, collected, and reported. The College and many other surgical societies have a great deal of experience in evaluating systems of care but little experience in measuring the performance of an individual physician. The theory that problems with surgical care can be addressed within the system of care is no longer a reasonable answer to health care stakeholders. Purchasers and payors of health insurance seek to assess individual surgeon performance, as well as the capabilities of health care systems. With the continued emphasis on transparency in health care, a cause that U.S. Department of Health and Human Services Secretary Michael

SQA MEMBER ORGANIZATIONS

American Academy of Ophthalmology
American Academy of Otolaryngology
American Association of Neurological Surgeons
American College of Obstetricians and Gynecologists
American Association of Orthopaedic Surgeons
American College of Osteopathic Surgeons
American College of Surgeons
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of General Surgeons
American Society of Plastic Surgeons
American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgery
Society of American Gastrointestinal Endoscopic Surgeons
Society of Gynecologic Oncologists
Society of Surgical Oncology
The Society of Thoracic Surgeons

Leavitt championed, performance and cost data will be made available to all stakeholders.

The SQA interacts with multiple national quality organizations tasked with improving health care and reducing costs through performance measurement and data collection, aggregation, and reporting. Formed in late 2005 under the direction of the College, the SQA comprises more than 20 organizations representing specialties involved in providing surgical care. Over the last two years, the complexity and purpose of the SQA have continued to grow. As a result, the SQA has recently added two vice-chair positions, which have been filled by representatives of the American Academy of Orthopaedic Surgery and the Society of Thoracic Surgery.

The SQA’s objectives are as follows:

- Define the principles of surgical patient quality measurement and develop awareness among

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Agency for Healthcare Research and Quality

<http://www.ahrq.gov/>

AMA Physician Consortium for Performance Improvement

<http://www.ama-assn.org/ama/pub/category/2946.html>

AQA

<http://www.aqaalliance.org>

CMS Hospital Compare

<http://www.hospitalcompare.hhs.gov/>

CMS Physician Quality Reporting Initiative

<http://www.cms.hhs.gov/pqri/>

Consumer Assessment of Healthcare Providers and Systems

<https://www.cahps.ahrq.gov/>

Massachusetts Health Quality Partners

<http://www.mhqp.org/>

National Committee for Quality Assurance

<http://web.ncqa.org/>

National Quality Forum

<http://www.qualityforum.org>

Surgical Quality Alliance

<http://www.facs.org/ahp/sqa/index.html>

Wisconsin Collaborative for Healthcare Quality

<http://www.wiqualitycollaborative.org/>

interested parties about issues related to surgical care and quality in all surgical settings

- Collate measures of surgical care quality, share methodologies across specialties to assist in the development of meaningful tools for quality improvement, and evaluate the use of registries
- Advance our own knowledge by serving as a point for disseminating information among spe-

cialty societies on quality-related initiatives in the federal and private sectors and for coordinating surgery's response to those initiatives

- Provide a forum for shared and coordinated efforts among the specialties so that our collective staff and resources can monitor and participate effectively in the many organizations involved in data aggregation and reporting, as well as the development, validation, and implementation of physician performance measures

Health care performance measurements are of growing interest to patient advocates, payors, and the major purchasers of health insurance as a means of increasing accountability and spurring internal quality improvement. (Additional information about the organizations mentioned in this article may be found in the sidebar on this page.) Many aspects of performance can be evaluated by measuring the structure, process, outcomes, and cost of care. Arriving at more complex measures of the efficiency and appropriateness of care are the next steps in better defining our health care system and improving preventive care and appropriate utilization of care.

The national organizations focusing on health care quality improvement include the National Quality Forum (NQF), the Agency for Health Research and Quality (AHRQ), the National Committee for Quality Assurance (NCQA), AQA (formerly the Ambulatory Care Quality Alliance), the Hospital Quality Alliance (HQA), the Quality Alliance Steering Committee, the American Medical Association's Physician Consortium for Performance Improvement (AMA's PCPI) and CMS. The creation of a multistakeholder community represents a significant change in the nation's approach to solving the health care challenges. For the first time, all stakeholders have been organized nationally in a forum focused on health care system redesign to improve quality and reduce waste. Buried within the matrix of performance measurements are sophisticated rules for defining and implementing a cohesive national set of measures that will be promoted for use by all payors.

The SQA formed as specialty societies realized the importance of serving as leaders for the surgical patients. Individual specialty efforts were quickly overwhelmed by the multiple programs already well under way and were unable to match

the efforts of multiple national meetings. The SQA brought forth a solution by allowing the surgical societies to share their resources and ideas about all aspects of quality improvement. Instead of a representative from every specialty trying to cover every call, meeting, and event, the SQA provides a structure for division of labor and dissemination of information among societies.

The SQA's initial foray focused on developing a starter set of "global" physician-level measures that would reach across most surgical disciplines. Working closely with the AMA's PCPI and under the leadership of the College, SQA representatives took positions on the consortium's workgroup for development of the Perioperative Care Measure Set. Each specialty contributed to the measure set, which includes six performance measures aimed at improving the use of appropriate antibiotic and venous thromboembolism prophylaxis. During the consortium's workgroup process, SQA membership reviewed clinical practice guidelines and other evidence-based literature to make determinations regarding the inclusion of procedures. In addition, the SQA participated in the review of public comments and refinement of the measure set. The PCPI approved the Perioperative Care Measure Set in October 2006, followed by approval by the AQA.

Once developed, measures can be submitted to the NQF for endorsement, which includes a rigorous review of the level of evidence, importance, usability, and feasibility of a measure. Once again, the SQA worked together to coordinate and collate evidence for each specialty involved in the Perioperative Care Measure Set. The measures have been approved by NQF's technical advisory panels and the project steering committee and are now in the NQF's public comment process. Through the hard work of the SQA members to develop a set of performance measures for surgery, surgeons from across the country were able to participate in the CMS Physician Voluntary Reporting Program (PVRP) in 2006 and will be eligible to participate in the CMS Physician Quality Reporting Initiative, which includes a 1.5 percent bonus payment on all Medicare claims, in 2007.

Collection of the clinical data that are needed to ensure compliance with these performance measures is done using the AMA's Current Procedural Terminology (CPT) within the provider coding and

billing system.[†] This requirement means the development of a measure must fit within the framework of an administrative system rather than a clinical decision support system. In addition, the current design relies on payor support for collection, aggregation, and distribution of the data. This presents operational problems for physicians whose patient population includes multiple payors. If data are collected by individual payors and never aggregated, performance determinations may be made on a very small number of cases.

With approved physician measures, each payor, including CMS, has interest in collecting and aggregating the measures for the purpose of assessing individual physician performance. The payor data registries allow each insurer to collect information on each claim for each provider. In order to create a comprehensive provider profile, all payors need a means of aggregating the collected data in a central, interoperable system. For example, a surgeon would submit claims data with the quality codes to the commercial payors, the insurance plans, and the federal and state fiscal intermediaries. Each payor would need to pass along the individual provider's performance data to a central repository. The central repository would return a report to each payor with an overview of the surgeon's comprehensive performance.

To create interoperable systems that would solve the data collection, aggregation, and reporting issues is a significant challenge. Meanwhile, several medical and surgical specialties have developed registries to assist in maintenance of certification and other quality and patient safety pursuits. More sophisticated data registries that reach beyond the administrative data and become part of a clinical decision support system seem the obvious next step for collection of physician performance data. The SQA has formed a Data Registry Workgroup to study a means for meeting the data aggregation needs of a physician measurement system. Many surgical specialties have well-developed registries, whereas others have no means of data collection. Harnessing the current surgical efforts into a set of data aggregation options that bring value to all surgical disciplines as well as other stakeholders is the goal of the workgroup.

[†]All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2006 American Medical Association. All rights reserved.

The SQA is exploring clinical registries as a means of collecting and aggregating data within each specialty society. These registries may operate through a portal that allows physicians to efficiently collect the performance measures by running collected data through quality analytics. The aggregated data would be shared with the payors and the surgical specialties to develop reports for quality improvement.

A key focus in performance measurement involves patient satisfaction. The SQA evaluated the existing patient satisfaction survey instruments and concluded that they lacked a surgical patient focus. To address this gap, the SQA formed a Patient Satisfaction Survey Workgroup, which will work on development of a tool for evaluating surgical care. Upon development of the survey, the SQA will submit the tool to AHRQ for approval as an official Consumer Assessment of Healthcare Providers and Systems survey. The project is on track for completion by January 1, 2008.

A major focus of the SQA is to increase surgery's cooperation and understanding of other health care stakeholders. In addition to participating in external quality organizations and initiatives, the SQA hosts three meetings per year at which other stakeholders are invited to share their perspectives with the SQA membership. Former presenters have included Carolyn Clancy, MD, director of AHRQ; Carol Flamm, MD, medical director for Blue Cross Blue Shield Association; Robert Berenson, MD, senior fellow at the Urban Institute; Tom Valuck, MD, JD, Medical Director and Senior Advisor at CMS; and Denise Remus, PhD, RN, vice-president of clinical informatics at Premier, Inc.

The SQA has also written multiple letters in an effort to present a consistent, unified message from surgery. Over the past two years, the SQA has sent formal letters to CMS regarding the PVRP; to NQF on surgery-related performance measures and in support of surgeons to serve on the NQF board of directors; and to the AQA, addressing concerns and challenges. In addition, the SQA provided formal comment to NCQA on its 2008 HEDIS (Health Plan Employer Data and Information Set) specifications. To respect the unique perspectives of each society, sign-on to SQA letters is optional. However, the SQA has enjoyed nearly unanimous support from societies for all correspondence.

As the SQA continues to evolve, we look forward to strengthening collaboration both internally with surgical specialties and externally with purchasers, payors, and patients. The SQA continues to develop projects that increase participation by member organizations and highlight each organization's strengths and focus. The SQA realizes performance measures will continue to evolve. The initial measures were basic measures of processes of care and limited outcomes. More sophisticated measures will include efficiencies in care and appropriateness measures. Properly developed measures are an essential step in reducing overutilized care and creating cost savings. In addition, the SQA is researching the role of risk-adjusted outcomes systems. The ACS hopes to launch a pilot for combining measures of provider performance, system performance, cost, and patient satisfaction.

The SQA outreach program will continue to invite experts to present at coalition meetings in these areas of quality and to partner with the SQA on relevant projects. As time passes, the SQA's mission, goals, and common message of quality improvement for patients continues to solidify. In the coming months, the SQA will begin to evaluate its membership structure and discuss the possibility of extending invitations to nonphysician organizations that participate in the care of surgical patients. Most importantly, the SQA will continue to educate its members and others about surgery's willingness to partner and collaborate with any organization trying to improve quality, efficiency, or patient satisfaction. [Q](#)

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