

Going Under the Knife? Be Glad If You Live in Washington State

One of the deep, dark secrets in health care is the tremendous variation in the ways surgical procedures are performed and the results of these different approaches between surgeons and hospitals. This variation relates to the geographical region where you live, the medical training of your surgeon and standards that your hospital has for the procedures that are put in place. Variations exist in everything from use of expensive tests to rates of surgical complications. These variations require reoperations, hurt patients and cost the health care system a tremendous amount of money.

One group in Washington State is working on reducing this variation. Through the Surgical Care and Outcome Assessment Program (SCOAP), the Foundation for Health Care Quality (<http://www.qualityhealth.org>) not only reduces variations, it saves lives and reduces costs as well.

Reducing Variations/Saving Lives

SCOAP was designed by surgeons and quality improvement experts to examine surgical practices at voluntarily participating hospitals in Washington State. To date, over 20 of the largest hospitals in Washington State participate, representing almost three quarters of the surgical care in the state.

SCOAP is based on the assumption that significant variation can be reduced by having clinicians and other stakeholders track variability and set up programs to combat that variation. SCOAP started by tracking high-volume and growing procedures, such as colectomies (colon surgery), bariatric surgery (gastric bypass for obesity), and common procedures such as appendectomies. For example, SCOAP has recently tried to tackle complications rates after colon surgery that requires reoperation. By looking at over 20 indicators of excellent care, SCOAP is helping change the way surgeons are doing business; getting routine testing for blood sugar levels for diabetics undergoing surgery to reduce the risk of major infection and testing reconstructions of the intestine for leaking during the operation so they can be detected early and fixed before they cause a problem.

SCOAP works with the hospitals to collect data and reports performance back to hospitals and surgeons on a quarterly basis. The hospitals can see how they perform compared to other hospitals from the region and learn from better performers how they can improve. Often better performers have initiated best practices. Clinical groups that focus on performance improvement or system changes can make certain that optimal care happens.

The results have been dramatic. Since its inception in the fourth quarter of 2005, the number of unnecessary appendectomies has dropped nearly in half, the rates of complications requiring repeat operations has fallen significantly, and the rate of patients receiving appropriate medications to prevent infections, avoid blood clots, and reduce heart attacks has increased dramatically.

For example, patients who take heart slowing medications such as Beta Blockers for heart disease need to continue taking those medications after surgery. Since patients may not be able to take pills after surgery, they must be given an intravenous Beta-Blocker or their risk of heart attack triples! At the start

of SCOAP many hospitals had no system in place to assure that the B-Blocker was continued, and in nearly 20% of the cases, Beta Blockers were not being continued (national estimates range from 20-40%). After a year and a half of SCOAP data putting this in the spotlight, many hospitals are doing it right 100% of the time.

Variation and Patient Safety

What is striking to a lay person, such as me, is the incredible variation that still exists across SCOAP hospitals in what one would think are pretty basic procedures. Even among SCOAP hospitals who are working on this and other issues, in testing for blood sugar prior to surgery on a diabetic patient, only 3 of the 10 participating hospitals consistently did that 90% of the time; one did that 70% of the time, and 3 were at 60%, which is the lowest baseline. Three hospitals were significantly lower, with one as low as 30% of the time.

In the blood clot medication study, of the 15 hospitals participating, 7 were at the 90% to the 70% level, one was at 60%, but seven were 30 to 40% levels and two did not give medication for blood clots at all.

What is truly exciting is that once the hospitals and the surgeons had this data, their performance changed. In the first quarter of 2006, fewer than 80% of the patients in the participating hospitals were given their antibiotics on time. By the fourth quarter of 2006, more than 90% of all patients were receiving antibiotics on time.

The rate of unnecessary appendectomies went from a high of 15% to less than 5% from 2nd quarter 2006 to first quarter of 2007.

In colon cancer surgery, some surgeons did not look past 5 or 6 lymph nodes for signs of cancer, when the standard should be 12. In the first quarter of 2006, less than 60% of all patients had the 12 nodes examined; by the 2nd quarter of 2007, over 70% of all patients had all 12 nodes examined.

What this means to patient safety and the quality of care is obvious. What it means in terms of costs from poor outcomes, infections and over all quality of care is often immeasurable.

The Only One in the Nation

What is exciting is that CodeBlueNow! is in a State where this program exists. What is frightening is that no other state is doing this in any systematic fashion. If such wide variation exists in 20 hospitals in Washington State—you know that same variation exists all over the country.

“This has been a genuine collaboration of the hospitals, their surgeons and quality improvement teams. We have a management team with representatives of the medical staffs of each participating hospital, as well as representatives from the Washington State Chapters of the

American College of Surgeons,” indicates David Flum, MD, Medical Director, SCOAP. “What we really have here is trust. We are succeeding because we can have all the stakeholders around the table--patients, purchasers, providers and payers. We are not using data to beat up doctors or hospitals. We use it to improve patient outcomes, quality of care and save lives. The Foundation has provided a safe haven for SCOAP development and frank discussions about variability and how to reduce it.

“Our vision is that the public also has a real interest in this data and should be a real stakeholder in their own health care. We want to gather data and make it as understandable and available to the public as much as possible. The delicate balancing act is in having hospitals voluntarily working on problems while there is tension to show the public the specific data they need to see. SCOAP is balancing the public’s right to know with this voluntary Collaborative’s interest in working on their problems and presenting their best face. The website includes information about participating hospitals, progress to date and will soon include performance data that the public can access to show that these programs work. Consumers may wonder how non-SCOAP hospitals perform compared to these leaders in quality improvement and that is a valid question. That’s why we think ALL hospitals should be in SCOAP,” Flum stresses.

Not Looked At Before

Why has this variability not been examined before? “Physicians know that variation exists, but with so many other pressures on reporting and quality measures, hospitals are forced to work on metrics that Medicare is forcing on them by reducing payment unless they perform well. I think that in the past we clinicians put our heads in the sand, hoping that Medicare doesn’t start to look at what we do, see how much practices vary, and force us to do things we may not agree with,” Flum states.

“As SCOAP shows us, this variation should be a clarion call to all physicians to take up their proper role in the health care system—assuring quality patient care—we are the sharp edge of the quality improvement knife and SCOAP restores the role of the surgeon in defining quality, measuring quality and improving quality.

“What SCOAP offers is accurate, actionable data,” Flum indicates. “We have our finger on the pulse of a major national issue—the quality of patient care—and a novel framework for making it better by empowering doctors to do the right thing. What we have here is data and action from people who hold the knife. Much of what we’re working on is common sense. It’s the type of thing that can best be done on a regional basis where surgeons and hospitals are linked together in a trusting Collaborative. We’re not necessarily competing against each other in SCOAP—we’re trying to be the tide that lifts the quality of all the boats in the state,” observes Flum.

Blazing New Trails

What remains remarkable is that no other organization measures outcomes in this manner. Medicare has a set of quality initiatives wrapped into their Surgical Care and Improvement Project (SCIP). SCIP requires hospitals to publicly report on their use antibiotics and will in the future force them to publicly report on other measures and outcomes. Medicare will pay hospitals less if

they do not report on those measures. The SCIP approach will likely improve the use of these metrics, “but they leave the doctors behind,” says Flum. “SCIP will help hospitals to do the right thing, but because the metrics are linked to payment they are very limited in number, allow no room for including common sense measures, and leave doctors in a responsive and defensive mode. The national American College of Surgeons has an important ranking system of hospitals that was borrowed from the Veterans Administration hospital system called NSQIP. NSQIP gives hospitals a ranking based on the number of deaths they have after surgery compared to the number of deaths that would be expected based on the severity of the patients treated at that hospital. Because NSQIP collects no data on what hospitals and surgeons actually do to get those outcomes, hospitals that underperform on NSQIP may know they have something to work on, but they just don’t know what.”

SCOAP differs from these other Quality Improvement programs because it puts clinicians—who are the source of variation—front and center in the Quality Improvement activity. It is an initiative designed to define, track, and act. According to Flum, the inspiration for SCOAP is the New England Collaborative for Cardiac Surgery which engaged cardiac surgeons and cardiologists to look at physician practices across several states and dropped the mortality rate of patients having heart surgery and interventions more than any other national region.

SCOAP offers a wrinkle on the concept of the Evidence-Based Medicine (EBM) movement. Advocates of EBM often limit interventions to the evidence from randomized trials. Very limited randomized trial data exists in surgery. “We can wait 30 years as all these elements of variation get submitted to randomized trials or we can use common sense, flexibility and an eye to improving procedures and act now. What we want to do,” Flum stresses, “is to get the people in the trenches to minimize the variability of procedures. While evidence based medicine is important, to stop at the randomized trial data would be a huge mistake in surgery—that’s not the way they improved cardiac care in New England and that’s not the biggest bang for our QI buck in Washington State, or anywhere else.”

So if you are headed for a hospital in Washington State, you might ask your surgeon if they are involved with SCOAP, and if not, why not. And if you are a clinician in another state, leadership opportunities abound!

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