Surgery, GME & Public Reporting

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Why Public Reporting

- Ethics: Autonomy - Patient Choice, Patient Centered Care
- Quality Improvement and Public Health - Public Assurance
- Costs and Market Based Payment - Reference Pricing
Ethics and Autonomy

- Autonomy
  - Patient Centered Care – decision making
  - Informed consent
  - Informed consumer

- How ????
Quality Improvement
Reducing Complications and Cost

82% OF HOSPITALS DECREASED COMPLICATIONS

66% OF HOSPITALS DECREASED MORTALITY

250-500 COMPLICATIONS PREVENTED ANNUALLY PER HOSPITAL

Potential savings 4,500 hospitals: $13 - $26 billion/year
Heath Care Reform
The Value Proposition

- Cornerstones
  - Measure and Publish Quality Reports
  - Measure and Publish Price
  - Create Positive Incentives
Reference Pricing: Consumer Cost Sharing

• Cornerstone for Excellence
• Transformation from possibility to reality

The Joy of Lifelong Learning
A Surgeon’s Professional Journey

Education Measurement
• What Should We Measure
• Currently have little Data
TRAINEES, PRACTICING SURGEONS, SURGICAL TEAMS
We Have A Problem

- Past Measurement: Attendance, Attestation, Written Exam
- Residents appear unprepared
  - Lack confidence
  - Exam performance concerns
  - Not producing what we intend
National Efforts

NATIONAL INVITATIONAL CONFERENCE on the FUTURE of SURGICAL TRAINING

May 24-25, 2017
Chicago, IL

1. Entry in Residency
2. Core Training
3. Final Training
4. Transition into Practice
Future of General Surgery Training
May 24, 2017

- American College of Surgeons
- American Board of Surgery
- RRC for Surgery
- APDS
- Topics, Ownership, Deliverables

- Boot Camps
- Core Training
- Duty Hours
- Competency-based Education & Skills Assessment - EPAs
- Mentored Autonomy
- Community Rotations/Continuity
- Objective Ongoing Progressive Self-Assessment and Feedback
- Capstone Autonomy
- Role of Surgeons in Residency Accreditation Process
- Faculty Development and Support
- Career-Long Record Keeping
- Public Education and Federal Regulations
ACS: 100+ Years of Quality Improvement

Minimum Standard for Hospitals: 1917
Committee on Trauma: 1950
Commission on Cancer: 1951
NCDB: 1988
ACS NSQIP: 2004
NAPBC: 2008
CQIP: 2013


AMERICAN COLLEGE OF SURGEONS
Inspiring Quality: Highest Standards, Better Outcomes
New Expectations

Professional Responsibility – The Five Phases of Care

Chapters

(Personnel and Committees)
  How a surgical quality program works, Surgical quality and patient safety committee, Chief quality officer
  Domains and phases of care

(Quality Improvement Process)
  Peer Review; Culture

(Disease Management)
  Multidisciplinary (Gen surg, Surg onc, Trauma, Acute care, Burns, Transplant, Vascular, Bariatric, Complex GI, etc.)

(DATA)
  Data Analytics

(Learning and Sharing)
  Education; Training; Guidelines; Consortiums

(The Individual Surgeon)
  CMS MIPS measures

WE SET THE STANDARDS FOR QUALITY
The Surgeon’s Responsibilities: Preoperative Evaluation Phase of Care

- **Appropriateness** for surgery
- Major medical conditions
- **Modifiable risk factors**
- Specific medications
- **High-risk patients – risk calculators**
- **Informed consent**
- Institution specific elements of surgical work-up
- Review of preoperative labs
- **Coordination of care**

**New Expectations**
The Surgeon’s Responsibilities: Immediate Perioperative Phase

- Pre-admission skin preparation
- **Updated history and physical assessment**
- **Confirmation of the correct procedure**
- Awareness of the patient’s personal effects and unique needs following surgery
- Confirmation of the availability of **family members** or patient representatives

- Appropriate **re-evaluation of critical laboratory values**
- Preoperative surgical **site marking**
- Allergy and last meal assessment
- Perioperative antibiotic selection and timing of administration
- **Perioperative use of critical medications**
- Anesthetic selection
- DVT/PE prophylaxis

**New Expectations**
The Surgeon’s Responsibilities: Intraoperative Phase

- Patient **positioning and padding**
- Appropriate grounding of electrocautery devices / fire safety precautions
- Intraoperative **time-outs and checklists**
- Equipment checklists, physical presence and functionality
- Prevention of hypothermia
- Glucose control
- DVT/PE prophylaxis
- Antibiotic re-dosing
- **Intraoperative use of critical medications**
- **Handoffs** when changes occur in the operative team
- Surgical and operative team safety
- Intraoperative planning of procedure, anticipation of anesthetic emergence
- **Correct count procedures**
- **Postoperative debriefing in the OR**
- Pre-transport decision making about destination, communication with receiving unit

**New Expectations**

The Surgeon’s Responsibilities: Postoperative Phase of Care

**Immediate order writing** and the use of postoperative order sets consistent with institutional guidelines for clinical conditions
- Advanced respiratory care
  - Routine cough, deep breathing and incentive spirometry regimens
  - Preventive measures for ventilator-associated pneumonia
  - Ventilator management
  - Extubation
- DVT/PE prophylaxis
- Stress ulcer prophylaxis
- Pressure ulcer prevention measures
- Pain management
- Positioning, limb elevation
- Timing of ambulation
- Line management
- Fluid and electrolyte management
- Nutritional management
- **Plan for resumption of preoperative medications**
- Draining and tube management
- **Ongoing bleeding management**
- **Patient education**: written verbal
  - Instructions on obtaining and properly taking medications
  - Planning for the resumption of preoperative medications
  - Before discharge, presentation of an itinerary of scheduled follow-up
  - Immediate follow-up at home, including phone calls
  - Discharge instruction sheets
  - When to call, Whom to call, How to recognize atypical pain, bleeding and infection

**New Expectations**

The Surgeon’s Responsibilities: Post-discharge Phase

- Instructions on drain and catheter management
- Dressing and wound management
- Resumption of physical activity
  - Ambulation
  - Driving
  - Sports
  - Sexual relations
  - Return to work
- Physical therapy
- **Special considerations for at-risk populations, uninsured or underinsured**
  - Resolving transportation issues
- Contact and follow-up with primary and specialty care provider
Team Based Models of Surgical Care

- Team models for surgical care are a best practice
  - Surgeons still need to assume leadership, strong collaboration, communication and partnership with the patient’s anesthesiologist, general internist and other medical and surgical specialists

- This sense of “teamness” should not replace the importance of the physician-patient relationship and the trust that the patient places in his/her surgeon to lead

Effective Surgical Leaders

- Compelling vision
- Sense of accountability
- Effective communication skills
- Excellent problem-solving abilities
- Capacity to think strategically and analytically
- Strong change management skills
- Relationship and consensus-building talents
- Mentorship capabilities
- Understanding of organizational behavior and culture

New Expectations

Using Data to Improve

Peer Review: A Forum for Quality Improvement

“The common sense notion that every hospital should follow every patient that it treats...with a view of preventing similar failures in the future."

- Ernest Amory Codman, MD, FACS

- It is the key means by which the profession regulates itself
- It is useful in identifying outliers and process deviations
- It can stimulate research and innovation to identify new ways to deliver quality care
What kind of “Culture”

Blame Free  Just  Punitive

New Expectations
CYCLE OF PRACTICE-BASED LEARNING AND IMPROVEMENT

- Identify Area for Improvement
- Check for Improvement
- Engage in Learning
- Apply New Knowledge and Skills to Practice
- New Expectations
ACS MODEL FOR VERIFICATION OF SURGICAL KNOWLEDGE AND SKILLS

Level I. Verification of Attendance

Level II. Verification of Satisfactory Completion of Course Objectives

Level III. Verification of Knowledge and Skills

Level IV. Verification of Preceptorial Experience

Level V. Demonstration of Satisfactory Patient Outcome

New Expectations

Sachdeva, Arch Surg, 2005
Simulation-based Surgical Education

- Consortium of ACS Accredited Education Institutes

Quality of Skills Training

- **Structure**
  - Training facility
  - Curriculum
  - Adequate instructors
  - Tracking system - SSR
  - Program funding

- **Process**

- **Outcome**
  - Metrics
  - Mortality
  - Margins
  - Open rates
  - Complications

- **New Expectations**
- Training standards
- Warm-up and practice standards
- Performance improvement program
Ongoing Surgical Competence

Assessment:

- Professional standing evidenced by licensure and hospital privileges
- Life-long learning and assessment, including documented CME and self assessment
- Cognitive expertise evidenced by success at secure examinations
- Future: Practice assessment confirmed by participation in local, regional or national registry/QA programs

New Expectations
Public Reporting Dilemma

- Patients: safe, effective, accessible care in environment where their voice is heard
- Purchasers/ Health Plans: emphasize safety, effective outcomes, appropriate use of resources, competition
- Physicians/ Providers: meaningful actionable performance feedback from reliable, accurate and valid sources, avoiding misclassification

New Expectations
Basic Tenets - Public Reporting

1. All reports should make their methodology publicly available
   1. data used to estimate performance
   2. use of statistical risk-adjustment techniques
   3. the selection of performance measures
   4. how surgical performance was categorized
   5. no use of ‘black box’ proprietary measures

2. Each report should be independently deemed reliable and valid prior to release

3. Reports must be transparent about the observation period

4. Include a statute of limitations within the public report.

5. Use proper risk adjustment, as determined by the appropriate specialty society, to ensure ongoing access for patients who are at higher risk

6. Ensure that specialty societies have an opportunity to provide input regarding physician measures

7. Standardize reporting format

8. Provide opportunity for individual surgeon review and appeals

9. Conduct pilot tests to determine usefulness and effectiveness of reports

10. Evaluate the extent to which the report fulfills its stated purpose

11. Public reports should not be used to establish the standard or duty of care owed by a health care provider

New Expectations
General Issues on Reporting

- Clinical data more accurate and relevant
- Attribution must distinguish between the primary surgeon and others
- Appropriateness criteria must be driven by evidence-based medicine
- Public reports must accurately describe surgeons’ practice profiles
- Data in reports must be defined by and relevant to procedures being reported

New Expectations

Patient Audience

1. Report on patient-focused measures that are more likely to be understood by and credible with patients
2. Public reports for patients should focus on elective surgical procedures
3. Tailor a report specifically for the surgical patient
4. Customize reports based on procedures, conditions, and populations of interest to the patient
5. Reports should provide a framework to foster patient understanding
6. Make information available at the time when patients are most likely to use it
7. Establish credibility of reports from the patient perspective

Physician Audience

- Consider principles crucial for physician engagement: Relevant, Timely, Complete, Accurate
- Tailor a confidential performance feedback report specifically for the surgeon
- Use leading major national organizations
- Report on the type of quality measures meaningful to physicians:
  - Donabedian’s system approach (structure, process, and outcome) and
  - AHRQ National Quality Measures Clearinghouse domains
    - Structural, Process of care, Outcome measures, Access, Patient experience, Appropriateness of care, Shared decision-making, Care coordination and care continuity

Consumer-Purchaser Alliance Disclosure Project 10 Measures

- Make consumer and purchaser needs a priority in performance measurement
- Use direct feedback from patients and their families to measure performance
- Build a comprehensive ‘dashboard’ of measures that provides a complete picture of the care patients receive
- Focus measurement on areas of care where the potential to improve health outcomes and increase the effectiveness and efficiency of care is greatest
- Require that all patients fitting appropriate clinical criteria be included in the measure population
- Assess whether treatment recommendations are followed
- De-emphasize simplistic documentation (check-the-box) measures
- Measure the performance of providers at all levels (for example, individual physicians, medical groups, ACOs)
- Collect performance measurement data efficiently
Pathway from PRO to PRO-PM

New Expectations

Registries can now do this
The Surgeon of the Future

- Lead safe high performance teams
  - Integration of surgical/nonsurgical skills
  - Part of systems of care
- Evidence based practice
- Outcomes data – public reporting
- Continuous, professional development
Redefining Professionalism

Autonomy → Collaboration

Authority → Evidence

Assertion → Measurement

Control → Transparency

Self-interest → Public interest

Professionalism = Accountability