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EDITORS' CHOICE

Quality improvement in gynecologic surgery: The new frontier

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The continual and disproportionate increase in health care costs without showing improvement has regulatory organizations and purchasers of surgical care demanding comparative documentation of surgical quality and outcomes. Support for implementing performance standards is derived from 2 risk-adjusted national surgical quality improvement programs which documented substantial decreases in perioperative morbidity and mortality. These dramatic improvements in patient outcomes and corresponding decreases in health care costs are transitioning to “pay-for-performance” for surgical disciplines. With the requisite budget-neutral environment, quality incentive payments will be offset by reduced reimbursement for substandard performances. For specialties that have not developed specific performance metrics, the implications are substantial. Therefore, the gynecologic surgical community has an exigent need to develop standards and methods to assess quality within our discipline that are specialty specific, equitable and risk adjusted.

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The new frontier in surgery is the continuous monitoring of system structures, perioperative processes, and surgeon performance to improve safety and quality. After publication of 2 reports from the Institute of Medicine, *To Err Is Human: Building a Safer Health System*¹ and *Crossing the Quality Chasm: A New Health System for the 21st Century*,² purchasers, payers, consumers of surgical care, and other stakeholders have become increasingly aware of variation in the quality and outcomes among hospitals and physicians. Because such variability generally denotes suboptimal structure, process, or performance

in the delivery of surgical care, these stakeholders are actively involved in organizations that focus on developing strategies for transparent documentation of surgical outcomes. Such documentation will allow discretion in choosing a facility and physician on the basis of the quality of surgical care. The current system for reimbursing physicians and hospitals does not provide a comparative assessment of quality and outcomes; this is a major concern for the Centers for Medicare and Medicaid Services (CMS), insurance companies, business coalitions, and our congressional representatives.

To date, professional gynecologic surgeon organizations such as the Society of Gynecologic Surgeons have been rather passive and have not been sufficiently represented in discussions of national initiatives to improve surgical quality. Gynecologic surgeons must be more engaged in determining quantifiable mechanisms

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that improve the quality of surgical care in our specialty and in developing specific metrics for subspecialty areas such as gynecologic oncology and urogynecology. Specialty-specific metrics should incorporate perioperative variables that affect the selection and performance of procedures, the intraoperative and 30-day postoperative morbidity, and the quality of life and other long-term outcomes. If gynecologic surgeons do not assume a proactive role in determining measures of quality assessment for surgical care in our specialty, other stakeholders will determine measures that undoubtedly favor their special interests.

Stakeholder interest in gynecologic surgery

Hysterectomy is the most frequently performed major gynecologic operation, and it is 1 of the most frequently performed surgical procedures in the United States. From 1994 through 1999, 5.5 of 1000 women aged 15 years and older underwent hysterectomy every year (approximately 600,000 hysterectomies per annum).³ According to primary discharge diagnoses, indications for hysterectomy during the latter 1990s were uterine leiomyoma (39%), endometriosis (18%), uterine prolapse (17%), cancer (10%), and other indications (16%). Surgeons generally believe that the quality of care they provide and the associated outcomes are equal to or better than that of their peers. However, the gynecologic surgery literature shows wide variability in perioperative morbidity and outcomes associated with hysterectomy. Considering the number of hysterectomies performed annually and the associated morbidity, hysterectomy is a primary target for quality improvement measures and will be scrutinized by all stakeholders.

A recent report described a prospective assessment of morbidity associated with all benign hysterectomies performed in Finland over a 12-month interval.⁴ The overall complication rate was 19%. Intraoperative complication rates for abdominal, vaginal, and laparoscopic procedures were 2.3%, 3.0%, and 3.2%, respectively. Postoperative in-hospital complication rates were 12.3%, 16.1%, and 8.4%, respectively; complication rates after dismissal were 2.5%, 4.2%, and 7.4%, respectively. Major perioperative complications included infection, hemorrhage, organ injury, thromboembolism, and death. The strength of this national quality assessment study is attributable to the prospective study design that used standardized data collection methods and included all women undergoing hysterectomy for benign disease. If one assumes that the hysterectomy-associated complication rate in the United States is also 19% and that the average additional cost per complication is \$5000 (a conservative estimate), the annual cost to the health care system would exceed \$500 million. Consumers, purchasers, and payers understandably are interested in defining quality metrics for

hysterectomy, and gynecologists must recognize the urgent need to participate in the development and implementation of quality improvement measures.

Quality improvement programs for surgery

To initiate a quality improvement program, one must identify details of processes and outcomes and factors that allow for risk adjustment. Initial quality improvement activities are best directed at a systems level by addressing structure elements and process issues that influence surgical outcome. Structure elements are hospital directed and include availability and functionality of equipment and staff expertise for operation and maintenance of equipment. Process issues include guidelines for surgical indications, designing and performing procedures, use of care pathways for appropriate and timely prophylaxis, effective and efficient pain management, and administration of appropriate and timely adjuvant therapy. Quality improvement measures secondarily should assess compliance and performance of individual physicians.

Using the right processes for the right procedure at the right time on the right patient will optimize short- and long-term surgical outcomes. However, without risk adjustment, patient selection will markedly influence outcomes. Evidence-based studies have shown that identifiable preoperative risk factors are associated with postoperative complications, length of stay, cost per episode of care, and survival.⁵ Risk factors such as serum albumin level, American Society of Anesthesiologists physical status, operative complexity, age, carcinomatosis, chronic obstructive pulmonary disease, functional status, obesity, smoking, diabetes, kidney function, and liver function also affect postoperative morbidity. Quality assessment methods must incorporate risk adjustments to allow hospitals and physicians to compare outcomes of hysterectomy and other surgical procedures; such adjustments thereby will assure development of fair and equitable benchmarks.

CMS surgical care improvement project

The CMS contracted with quality improvement organizations in each state to work with hospitals and physicians and implement the Surgical Care Improvement Project (SCIP). SCIP, scheduled for implementation in July 2006, aims to reduce postoperative morbidity and mortality by 25% over a 5-year interval. SCIP is designed to reduce the incidence of surgical site infections, adverse cardiac events, deep venous thromboses, pulmonary embolisms, and postoperative pneumonia.⁶ SCIP processes will focus on the administration of appropriate prophylactic doses of anticoagulant medications, antimicrobial agents, and β -blockers at the

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