



Original article

Assessing national provision of care: variability in bariatric clinical care pathways

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Abstract

Background: The American Society for Metabolic and Bariatric Surgery (ASMBS) Quality Improvement and Patient Safety (QIPS) Committee hypothesized that collecting and sharing clinical pathways could provide a valuable resource to new and existing bariatric programs.

Objective: To shed light on the variability in practice patterns across the country by analyzing pathways.

Setting: United States Centers of Excellence

Methods: From June 2014 to April 2015, clinical pathways pertaining to preoperative, intraoperative, and postoperative management of bariatric patients were solicited from the ASMBS executive council (EC), QIPS committee members, and state chapter presidents. Pathways were de-identified and then analyzed based on predetermined metrics pertaining to preoperative, intraoperative, and postoperative care. Concordance and discordance were then analyzed.

Results: In total, 31 pathways were collected; response rate was 80% from the EC, 77% from the QIPS committee, and 21% from state chapter presidents. The number of pathways sent in ranged from 1 to 10 with a median of 3 pathways per individual or institution. The majority of pathways centered on perioperative care (80%). Binary assessment (presence or absence) of variables found a high concordance (defined by greater than 65% of pathways accounting for that parameter) in only 6 variables: nutritional evaluation, psychological evaluation, intraoperative venous thromboembolism (VTE) prophylaxis, utilization of antiemetics in the postoperative period, a dedicated pain pathway, and postoperative laboratory evaluation.

Conclusion: There is considerable national variation in clinical pathways among practicing bariatric surgeons. Most pathways center on Metabolic and Bariatric Surgery Accredited Quality Improvement Program (MBSAQIP) accreditation parameters, patient satisfaction, or Surgical Care Improvement Protocol (SCIP) measures. These pathways provide a path toward standardization of improved care. (Surg Obes Relat Dis 2016;■:00–00.) © 2016 Published by Elsevier Inc. on behalf of American Society for Metabolic and Bariatric Surgery.

Keywords:

Bariatric surgery; Quality; Quality improvement; Clinical care paths; Care maps; Pathways; Accreditation; ASMBS, MBSAQIP

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Implementation of clinical pathways began in the late 1980s with the intent of improved healthcare delivery and quality while minimizing healthcare costs [1]. By 2003, clinical care paths were present in over 80% of hospitals

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within the United States [2]. The value of such pathways is well recognized in bariatric surgery. Maintenance of and adherence to clinical care pathways are mandated as a requirement for accreditation by The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) [3].

The commitment to dedicated patient care maps requires an enormous commitment of resources as well as “buy-in” from provider stakeholders. Whereas the intent of clinical care paths is to streamline and improve care, not all patients and providers identify these pathways as valuable adjuncts to care. Many feel care paths represent additional administrative burden without the addition of much value. Individual studies within the literature are varied and contradictory as to the impact of pathways to patient outcome [4–7]. This variability is partly blamed on lack of pathway standardization and absence of a unified definition of what constitutes a clinical pathway. One recent meta-analysis identified 84 different terms within the literature that could be considered synonymous with pathway [8]. This lack of a uniformly accepted definition impacts the capability for true program evaluation.

The Quality Improvement and Patient Safety (QIPS) Committee supports the mission and values of the American Society of Metabolic and Bariatric Surgeons (ASMBS) by promoting continuous improvement in patient safety and risk reduction. These goals are achieved by the integration and coordination of patient safety initiatives to reduce medical errors through process analysis and participation in quality improvement reporting. This committee recognized the importance of clinical pathways and that although mandated by MBSAQIP, little was known as to the content and variability of such pathways on a national level. We hypothesized that collecting and sharing established successful pathways could ultimately provide a valuable resource to support new programs as well as help existing programs improve patient safety. Additionally, analyzing these pathways would also demonstrate the variability in practice patterns across the country.

Materials and methods

As this study did not involve the use of animal or human patients nor carry any risk for disclosure of patient identified data, it was deemed exempt from Institutional Review Board (IRB) approval. From June 2014 to April 2015, clinical care pathways pertaining to preoperative, intraoperative, and postoperative management of bariatric patients were solicited from the ASMBS executive council (EC), QIPS committee members, and state chapter presidents. Directed emails were sent and practitioners contacted by phone in an effort to obtain pathways. Received pathways were then de-identified as to the institution and practitioner at the sender’s request.

Clinical pathways were then analyzed based on predetermined metrics pertaining to preoperative, intraoperative, and postoperative care. These metrics were preselected based on current practice patterns and approved by both the QIPS committee chair and pathway subcommittee. Table 1 lists these metrics. Pathways were then evaluated for level of detail and assessed for mention of these metrics. Concordance and discordance between the pathways were then analyzed and reported. Concordance on a variable was defined as mention of the metric in greater than or equal to 65% of pathways. Fisher’s exact test was utilized to compare categorical values. *P* values less than .05 were considered significant.

Results

In the 10-month solicitation period, a total of 32 individuals provided clinical pathways related to the care of bariatric patients. The response rate was 78% (*n* = 7) from the EC, 80% (*n* = 16) from the QIPS committee and 22% (*n* = 9) from the state chapter presidents. The number of pathways sent in ranged from 1 to 10 with a median of 3 pathways per individual or institution. The majority of pathways centered on perioperative care (80%). Of note, no significant difference was reported between pathways obtained from large academic centers versus community hospitals or private practice (44% versus 56%, *P* = .45), respectively.

Binary assessment (present or absent) of variables were assessed by 3 individual reviewers and results are presented in Table 2. A high concordance, as defined by greater than 65% of pathways accounting for that parameter, was found in 6 variables. Those variables included: preoperative nutritional evaluation (71%), preoperative psychological evaluation (67.4%), mention of intraoperative venous

Table 1
Preoperative, intraoperative, and postoperative variable assessed for in clinical pathways

Preoperative	Intraoperative	Postoperative
Duration liquid diet	VTE prophylaxis	Anti-emetics
Endoscopy	Foley catheter	VTE prophylaxis
Sleep apnea screening	Patient positioning	Initiation of diet
Bowel Preparation	Antibiotics	Anticipated LOS
H. Pylori Testing	Drains	Duration of diet
Mandatory weight loss	Leak test	Acid suppressing meds
Cardiac evaluation	Endoscopy	UGI
Chest x-ray	Staple line reinforcement	Pain management
Nutritional Evaluation	Bougie use	Monitoring
Psychological Evaluation	Distance from pylorus	Laboratory studies
DVT screening		Time to postop visit

DVT = deep vein thrombosis; H. pylori = *Helicobacter pylori*; LOS = length of stay; UGI = upper gastrointestinal series; VTE = venous thromboembolism.

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