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Melanoma: Improvement in guideline based care using a quality monitoring program. Comparison of melanoma care outcomes in a community-based teaching hospital☆

DR. LEONARD HENRY (Goshen, Indiana): Parts of this paper, reading it made me quite happy and parts of it left me a little bit blue. But I will start with the happy. It's great to see you as a surgical resident involved in quality improvement initiatives, and I congratulate you and your coauthors for implementing this quality assurance tool in your center for the people in Grand Rapids and the region. That's no easy task.

And so the first question I have for you has to do with that, which is who paid for this? How was it implemented? How many people does it take? Is there a cost that you can estimate for an organization that might want to do this? And, secondly, this seems like a system quite a lot like NSQIP. Some literature suggests that it's not actually the reflection on the outcomes that spurs improvement, but process – or quality improvement initiatives that stem from it. And I ask you, secondly, in this paper, what were some of those quality improvement initiatives that the review of the data stir?

And then when people discuss health care quality, sometimes they talk in terms of structure, process and outcomes, as you did. In reviewing this paper, it seemed as though the vast majority of these measures were process measures. But I'm curious if there's actually a very important structural measure in your center; namely, who was doing the melanoma operations before the time break in the study and who was doing them after? Are the improvements really a reflection solely on this abstraction tool or are they more reflective on a well trained clinician with a passion or a specific skill in melanoma care?

And now briefly the part that made me blue, I am going to put on an MBA hat for this, but I want to say that I think, when I think of medicine in terms of business, the business world is far ahead of us in measuring quality. And I think business leaders understand there are many types of quality, and the definition is very much up to the customer.

In a business, it's generally felt to be a mistake to talk only about the features of a product, but generally the emphasis is on the benefits. And if your product is not a commodity, meaning that all the units of production are the same, it's more important actually to make your product perform its quality better than your competitors rather than just conforming to someone else's standards.

So my question for you, from my perspective, this paper is mostly about conformance quality and that the monitoring tools like these are most useful to bring previous suboptimal care or previously suboptimal documentation of care to a standard of care but not much further. It also focuses on the features of care and leads us to wonder where the benefits are, and you've explained that a little bit.

And so my last question for you, is this paper, like many other quality improvement papers in surgery, able or simply raising what is apparently a very low bar in cancer care, or is it furthering the path of health care toward becoming a commodity, service or both?

DR. HIELHORN: As far as cost, unfortunately I don't have a number, but is, I have to say, probably substantial. And then you got a general surgical resident abstracting data and it required multiple people in the research department; namely, clinical informatics person to develop the database and then facilitate database changes which did take time, and then a full time – well, it was full time, now part-time clinical research nurse who then took over data abstraction towards the end of my tenure as a resident. Then the surgical oncologist to oversee you with the monthly meetings initially and then the quarterly meetings thereafter. So although I don't have a monetary value to put on it, I would say that developing a database like this is not cheap, and that's where some of the discussion comes in as far as your final point, was there value in this. And I think that's one of the things Porter tried to get into a little bit, and his editorial was, where is the value with these quality metrics, and at what point is it important to continue developing databases like this to facilitate improvement and where is the improvement?

I think part of the improvement from the pathology front was the fact that this fostered an environment of communication between the pathology department and the surgeons within the program, as well as the medical oncology team and tumor board for some of the more complex cases, which ultimately developed into a synoptic reporting and carryover of certain details in the pathology reports. As far as who's performing the cases, that's a huge point. And in 2013, the facility did hire a surgical oncologist who has a unique interest in melanoma. So I think that's a significant factor here in that it had previously been general surgeons, and the documentation was lacking significantly in the operative notes, as well as the preoperative consultation documentation. We've also seen some of these, as we abstract data, if the surgical oncologist isn't the only one undertaking the procedures, we've seen the other surgeons kind of heads towards this improved documentation for melanoma as well. Your final question's unique in that quality in terms of conformance quality, I am going to take a stab at it and say, I think we'll see what happens as far as if we can really a identify true improvement in terms of the classical outcomes. If we're looking for the final endpoint being death or disease-free survival, it's going to take time and significant increase in size of a program

☆ Presentation given by Barrett Kielhorn, M.D.

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like this to really identify that.

DR. SCOTT WILHELM (Cleveland, Ohio): In your early group for five years, you had 27 patients, and then your late group for four years, you had 270 some. I'm curious if the implementation of your program, did that increase your referral pattern? You may have answered part of it, too, because I heard you say you guys hired a surgical oncologist in 2013, which was your break point. But I'm just curious like what brought this expansive melanoma to you guys all of a sudden?

DR. HIELHORN: As we identified the improvement in metrics and these became published by the marketing department, the referral base improved significantly, including both dermatologists, as well as primary care physicians.

DR. WILHELM: That may help you answer your question that just by creating this, in term of product, perhaps you are actually going to increase access for those patients because you get better referral for people knowing that you guys are making an effort to improve quality and that may lead to a better long-term product.