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Quality that you cannot believe[☆]



DR. ALAN P. LADD (Indianapolis, Indiana): I congratulate them on undertaking assessment of the administrative data set to which we are all held accountable. The authors in their study present their latest work around health care quality through their focused examination around outcomes reporting through institutional administrative data sets. Specifically as we have heard, they have attempted to uncover the complexities of an administrative data set on complications arising from surgical procedures and validate them against their own physician-derived outcome data set. To this end, the authors have clearly described the poor correlation between the two data sets. In attributing the physician-derived data set as a benchmark in defining true outcomes, the administrative data set shows a force specificity to reported surgical complications and often an under reporting of true complications.

From the manuscript and presentation, then I have the following questions for the authors: The authors clearly describe in their method the variability in the postoperative outcomes reported from each data set is directly impacted by the distinctly different definitions that are applied in cataloging those outcomes. You have such a comparison of data sets with distinctly different foundations valid in analyzing the predictive value of the administrative data set in question. Or in consideration of that question, can the physician-derived data set be considered the gold standard for capturing surgical morbidity? The authors in their manuscript discussion, which as an aside I highly recommend to the membership for its thoughtful insight, identify that the Achilles' heel of the administrative data set not only lies in its foundational definitions of morbidity, but also on its reliance on documented record of patient care and the relative inaccuracy of that record to depict clear outcomes. Would not an analysis demonstrating such a poor predictive value of the administrative data set merely be an indictment of the quality of current documentation to clearly and accurately describe patient outcomes?

The authors propose that surgeons should be more attentive to the documented record of patient care to improve its reliability and that time and resources are needed for surgeon engagement. Do the authors have specific examples of best practice in order to achieve such a desired practice?

Lastly, as the authors have elucidated the pitfalls of administrative database in its current form, what other recommendations or next steps do they currently advise in order for the administrative database to evolve toward the desired level of accuracy that will best depict the outcomes of surgical care.

DR. HENRY: I appreciate the incisive and practical questions.

First, regarding validity, when I think of validity, I think, did we measure what we intended to measure? And from my perspective, I think the answer to that is yes. The more important question from my perspective is, are administrative data really valid in assessing surgical outcomes? To that, I would answer probably no, but, obviously, this paper is stacked against the administrative data, because a large percentage of what defines a major complication is coming from the physician-derived data.

So the second question, is there a gold standard? Is reporting like this the gold standard? I don't know the answer to that. I've had a lot of conflicting thoughts about what actual quality is, so lately I'm not saying that one method may be superior to another. I'm just saying the way physicians see surgical quality and complications tends to be, I think, completely different from the way the payers see surgical quality and complications. So, you know, I would always encourage physician groups to pay attention to their own outcomes obviously. And I think it's even more important today because the stakes are even higher. Some of these things are showing up on third-party websites.

Regarding documentation, yeah, that's part of it. But I think it's generally a small part of it. I think it's important for surgeons particularly to kind of have an understanding of what standard criteria for certain diagnoses are, and not in a broad list, but particularly the things that the government is interested in. What's the threshold for renal failure? What's the threshold for defining shock or sepsis? What's the threshold for respiratory failure? Our friends, most of the renal failure, respiratory failure problems actually don't come from the surgeons documenting. It comes from the hospitalists and the intensivists documenting that, for which they're probably encouraged to do it.

So the next question of best practice for identification, I can't recall exactly. Can you clarify what that question, or maybe it was the next steps.

DR. LADD: Yes, it is.

DR. LEONARD: Anyway, what would we do next? I think it's really important that somewhere in somebody's hospital or institution in the basement, probably, there is someone or a group of people who are dealing with these data daily. Maybe they're clinical documentation improvement people. Maybe they're tied into your overall quality scorecards or tied into the government programs for value payments. I would encourage each surgeon to go down there and simply ask them for a report. They can generate a report like this.

And so if you have any idea of what your personal outcomes are or your group's outcomes are, you'll be able to compare these two things quite readily. And it won't be subtle. When I first looked at the report, it was obvious there were huge discrepancies in what

[☆] Presentation given by Leonard Henry, M.D.

was being considered serious complications.

DR. CHRISTOPHER R. McHENRY (Cleveland, Ohio): I just had a question and a comment, and I want to begin with the question. The question is, what are you going to do really now with your findings? What are you going to do or what are you going to attempt to change? When I was listening to your talk, I had a hard time initially kind of clarifying why should the physician-derived data actually differ from the institutional or the administrative data when you're both using the same electronic medical record to get the data from?

So if you're both using the same data, it seems to me that the way learn from this, is maybe you ought to come up with some standard definitions of complications that both your physicians and the people who are creating these administrative databases use. So I'd be interested in hearing your comments.

DR. HENRY: My sort of goal for all – I think institutions, if they feel like they have good programs, really need to put out their own data. And so that would be our next step, which is actually to put something like our outcomes and how we see them on our website and put them out there sort of as equally digestible information in the public compared to what comes out from other third payers.

DR. LAURENCE McCAHILL (Wyoming, Michigan): The cost of all this, you suggested, and it's true, there's people in the basement who are doing this coding. You don't know about their training. They don't understand medicine the way you do. And then if surgeons are going to go around and correct these people all the time with their own personal data sets, there's just a huge cost to all that. I just don't know what the solution is. There's been a lot written recently about the cost of quality, and it's immense to try to get it right. Yet I do think there's hospitals out there that game the system to show lower quality because of the pressures now on these Medicare publicly reported websites, Leapfrog. I mean, you're not really incentivized now to document your complications particularly well, because then it will just turn into public reporting. So it's really a big problem.

DR. HENRY: Thanks for the comment. I mean, you certainly can't tackle all of it. I would say if you look at a report on your practice or your institution, one or two red flags will certainly pop up – in our institution, renal failure and respiratory failure. We go right to our hospitalists and right to our intensivists and try to get them sort of on a NSQIP sort of definition of what those complications are.