ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SUBMISSION TO THE MEDICAL COUNCIL OF NEW ZEALAND ON PROVIDING PUBLIC REPORTS ON SURGEON PERFORMANCE

JUNE 2015

Submission on Providing Public Reports on Surgeon Performance

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand.

The College is a not-for-profit organization that represents more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates. RACS also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. There are nine surgical specialties in Australasia being: Cardiothoracic surgery, General surgery, Neurosurgery, Orthopaedic surgery, Otolaryngology Head-and-Neck surgery, Paediatric surgery, Plastic and Reconstructive surgery, Urology and Vascular surgery.

Executive Summary

The New Zealand National Board of the RACS supports the public release of outcomes-based data on surgical performance at a team, institutional or national level with a number of caveats.

The College supports the release of appropriate public reports that are valid, reliable and that establish trust so that providers and their patients can be confident that reports accurately reflect health care.

The College does not support the release of reports on individual surgeon performance but does support the release of reports on institutional performance.

The College does not support the concept of league tables but does accept that outliers be reliably identified and managed.

The following are recommended basic tenets for public reporting:

1. The methodology for collection of data should be publicly available and include a detailed description of any data that are used to estimate performance, the use of statistical risk adjustment techniques, the selection of performance measures and how surgical performance was categorized. It must be possible to audit the report results.

2. Reports should be independently deemed reliable and valid.

3. Reports must be transparent about the observation period including the differentiation between long-term follow-up and short-term outcomes.

4. There should be a statute of limitations within a public report. Outdated reports must be removed from circulation.

5. Reports should use proper risk adjustment, as determined by the appropriate specialty society, to ensure ongoing accuracy for patients who are at higher risk of complications and poor outcomes.

6. Specialty societies should have the opportunity to provide input regarding institutional or team measures chosen for public reporting.

7. There should be a standardized reporting format.

8. There should be the opportunity for institutional or team review and feedback before reports are released.

9. Pilot tests to determine usefulness and effectiveness of reports should be conducted.

10. Reports should be evaluated to ensure that the report fulfills its stated purpose and to identify any unintended consequences.

11. Public reporting should not be used to establish the standard of care or the duty of care of a healthcare provider.

Public Reporting Of Performance Data

The College considers that the purpose of publication of performance outcomes data is to improve the quality of medical care and to improve the public trust and confidence in the delivery of medical care.

The College recommends that the public reporting of outcome data should include all sectors of health care delivery and not be confined to the surgical specialties.

The College recognizes that the public release of surgical data my have unintended consequences that may impact on the delivery of quality and safe healthcare.

The College is cognizant that the reporting of surgical performance is occurring in other countries, including the United Kingdom and the USA. The healthcare systems in these countries are different from New Zealand and therefore the public reporting of surgical performance may not be transferable, or even generalisable.

The College notes that the Royal College of Surgeons of England is working towards improved methods of ensuring high standards in surgical practice through public reporting of operation outcomes[1]. The RCS Eng. believes that a reliable system of measuring outcomes will have many benefits including:

- Greater public transparency and accountability.
- Enable surgeons a better basis for judging and improving their practice.
- Offer patients the basis to make informed choices about their care.
- Provide evidence for service improvement and quality assurance.
- Provide better data when making funding decisions.

The American College of Surgeons in collaboration with a number of other Colleges and institutions has produced guidelines on the public reporting of surgical performance[2]. The Surgical Quality Alliance group recommends that data released should be accurate, valid, reliable and in context. This group has established a number of basic operating tenets of provider public reporting that in principle is supported by the College.

Methodology for Data Reporting

The methodology for collection of data should be made publicly available and include a detailed description of; any data that is used to estimate performance, the use of statistical risk adjustment techniques, the selection of performance measures and how surgical performance was categorized. It must be possible to audit the report results.

Rigorous statistical analysis is required to avoid the misrepresentation of the quality performance of institutions, teams and surgeons in public reports. Reports should include a

[1] https://www.rcseng.ac.uk/media/media-background-briefings-and-statistics/measuring-surgical-outcomes 2014
[2] Surgery & Public Reporting: Recommendations for Issuing Public Reports on Surgical Care. Surgical Quality Alliance. American College of Surgeons 2014

common set of clinically relevant measures that have been properly evaluated for fairness and accuracy so data can be compared across broad populations for meaningful analysis. All reports should make the methodology publicly available and should include a detailed description of any data used to estimate performance, use of statistical risk adjustment techniques and the selection of performance measures. Data should include how surgical performance was categorized.

Reliability and Validity of Reports

Reports should be independently deemed reliable and valid.

Details of volume should be included to ensure that reported data are statistically robust. With risk-adjusted data, minimum volume levels should be reported to ensure that the data is excessively representative of the surgical group. Reports on institutions with too few procedures to accurately characterize performance should not be included in public reporting. Such reports should include a statement that an inadequate number of procedures does not allow a meaningful analysis, but in no way reflects upon the performance of the institution.

Transparency of Reports

Reports must be transparent about the observation period including the differentiation between long-term follow-up and short-term outcomes.

Reports must be transparent about the information in given quality measures, including an explanation of the measures' observation period. Focus on short-term outcomes may be inappropriate for some procedures and may not help to meet patient expectations. For example, 30-day mortality may be appropriate for some cardiovascular procedures but not for Otolaryngology, head neck procedures that would normally carry a low 30-day mortality. Results from these 2 groups may therefore not be comparable. Similarly the short term follow-up of major joint replacements may not reflect the long-term outcome.

Statute of Limitations

There should be a statute of limitations within a public report. Outdated reports must be removed from circulation.

As a minimum, or public reports should clearly indicate the following information in this statute of limitations:

- Date of creation
- Date of the most recent update
- Date of expiry
- Inclusive dates for the data used in the report
- What data has been included or excluded from the report

Risk Adjustment

Reports should use proper risk adjustment, as determined by the appropriate specialty society, to ensure ongoing accuracy for patients who are at higher risk of complications and poor outcomes.

Conditions that increase the complexity of surgery are difficult to convey accurately in performance reports. There can be significant differences in the course of disease or outcome between groups of patients with the same diagnosis. Factors that influence the outcome not only include patient comorbidity but also socio-economic status, the prevailing health system, and health resources available in that community. With the health system's scarcity of resources the most urgent cases and those in most need are usually dealt with in the public hospital sector. These patients may not be comparable with the population group operated on in the private sector and this may be reflected in the outcome data.

Input from Specialist Societies

Specialty societies should have the opportunity to provide input regarding institutional or team measures chosen for public reporting.

Surgeons are familiar with the scope of practice, clinical management, and published research associated with their craft group. To ensure that measurement outcomes and data accurately reflect surgical care it would be appropriate for the various surgical groups to review the measures to be reported. Each subspecialty can decide and rank the importance of which quality measures best reflect their care.

Standardized Reporting

There should be a standardized reporting format.

Report format and content should be standardized in order to provide clear and comprehensible presentation of data. Without a standardized format patients would not be able to make comparisons for well-informed decisions about their care.

Review and Feedback on Reports

This should be the opportunity for institutional or team review and feedback before reports are released.

Adequate time frames should be allowed for institutions or teams to review reports prior to publication. Mechanisms should be in place to allow institutions or teams to verify the content of reports, submit feedback and to allow reports to be reworked prior to publication. In addition to reviewing data contained within the report, an explanation of the methodology should also be provided. If individual physicians or surgeons are reviewing reports the individual's data should be made available to that individual so that their data can be validated appropriately.

Pilot Testing of Reports

Pilot tests to determine usefulness and effectiveness of reports should be conducted.

Reports should be highlighted to test the effectiveness of the report on the intended audience. Highlighting of reports will allow provision of confidential feedback to providers to build provider trust. It is likely that clinicians will be more likely to release data if they have trust and confidence in the methodology and results.

Evaluation of Reports

Reports should be evaluated to ensure that the report fulfills its stated purpose and to identify any unintended consequences.

As stated previously, the purpose of publication of individual or team performance data is to improve the quality of medical care and to improve the public trust and confidence in the delivery of medical care. Care should be taken that there are not unintended consequences with the publication of performance data. There is literature to suggest that the publication of individual performance data may lead to risk-averse behaviour. The best clinicians may be those who manage the most complex and difficult patients and this may be reflected in the performance outcome measures.

Data within reports should be timely and reflective of current performance of standards of care. Historical data carries a risk of being less complete and less reliable than data collected contemporaneously. Moreonver,outdated material may not reflect current performance because of changes in technique or technology. Some measurements can become irrelevant after new evidence and research is published. Public reports should be reflective of changes

to ensure that the most current practice is reported. For this reason public reports should be subject to a statute of limitation and removed from circulation once expired.

Standards and Duty of Care

Public reporting should not be used to establish the standard of care or duty of care owed by a healthcare provider.

The standard of care should be clearly defined prior to the release of any public reports. While it is expected that in most cases the quality of care will exceed that, the defined standard the identification and management of outliers will generally increase the general standard of care across all groups. It is recognised that not every individual, team or institution can be the best performer so their performance should not be the benchmark for all other providers.

Additional reading:

Medicare's Physician Value-Based Payment Modifier – Will the Tectonic Shift Create Waves? Chien AT & Rosenthal MB. N Engl J Med 369;22, November 28, 2013 p 2076-8

Grading a Physician's Value – The Misapplication of Performance Management. Berensen RA & Kaye DR. New Engl J Med 369;22 November 28, 2013 p 2079-81

The Professional Attributes of Surgeons. Clare Marx Ann R Coll Surg Engl (Suppl) 2014;96:220-222

Individualised surgical outcomes: please look the other way. S R Moonesinghe. Postgraduate medical Journal December 2013 volume 89 number 1058 page 677 – 678.

Developing Observational Measures of Performance in Surgical Teams. A N Healy, S Undre, C A Vincent. Qual Saf Health Care 2004 13 (suppl) i33-i40

Publishing individual surgeons' death rates prompts risk adverse behaviour. S Westaby BMJ 2014;349:g5026 doi: 10.1136/bmj.g5-26 (published 12 August 2014)

Analyzing :failure to rescue" Is this an opportunity for outcome improvement in cardiac surgery .Reddy HG, Shih t, Englesbe MJ, Shannon FL, Theurer PF, Herbert MA. Et al.. Ann Thorac Surge. 2013;95:1976-81

Berwick DM A Primer on leading the improvement of systems. BMJ 1996;312:619-22
Agency for Healthcare Research and Quality. US Department of Health & Human Services. www.qualitymeasures.ahrq.gov/content.aspz?id=47545

Complications, failure to rescue, and mortality with major inpatient surgery in medicare patients. Ghaferi AA(1), Birkmeyer JD, Dimick JB. Ann Surg. 2009 Dec;250(6):1029-34.

Uses and Abuses of Performance Data in Healthcare. Shaw J, Taylor R, Dix K, Dr Foster Intelligence in Healthcare. April 2015

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