The Surgical Quality Alliance

THE American College of Surgeons (ACS), founded in 1913, represents more than 70,000 surgeons. The College's mission is to improve the care of the surgical patient and to safeguard the standards of care for an optimal and ethical practice environment. In 2005, the College formed the Surgical Quality Alliance (SQA) to coordinate national strategies for the subspecialties responsible for the care of the surgical patient. The SQA is a collaborative of more than 20 surgical and anesthesia specialty societies with the purpose of defining the principles of surgical patient quality measures and sharing in the development of meaningful tools for quality improvement. It also serves as a forum for coordinated efforts among the specialties to affect federal and private sector initiatives. The SQA provided the organized clinicians' voice for the surgical patient in a Washington, D.C. discussion that was dominated by primary care concerns.

"This collaboration will help address gaps in care that exist for our surgical patients by sharing the data between surgery and anesthesiology."

The effect of the SQA began to take shape with the development of nationally adopted measures for the surgical patient, a surgical patient experience of care survey, political updates on congressional activities, and a coordinated strategy in national quality forums. The goal of this strategy was to achieve equivalent representation for the surgical patient in committees that were dominated by primary care concerns. The surgical patient is now well represented by surgical clinicians in the Ambulatory Quality Alliance, National Quality Forum, American Medical Association Physician Consortium on Performance Improvement, and the National Committee for Quality Assurance, as a result of the discussions and strategy developed in the SQA. The participation of the leadership from the previously mentioned policy committees in current SQA meetings is a tangible reference for the success of the coordinated surgical strategy implemented by the SQA.

The development of a surgical registry was the next order of business for the SQA. In 2008, the SQA began the ambitious plan to develop a Surgical Data Registry, which would include data from 20 surgical and anesthesia specialty societies. The high amount of enthusiasm in the SQA surrounding this project was not able to overcome the complexity of the goal and the disparate registry development among the SQA members. For example, the American Quality Institute (AQI) did not emerge as a vision of the American Society of Anesthesiologists until 2009. Due to this splintering, the SQA adopted a new tactic to achieve the goal of a comprehensive surgical registry. In 2011, the ACS used the individual surgeon's Case Log Platform to develop the Surgeon Specific Registry (ACS-SSR) under the guidance of Frank Opelka, M.D., F.A.C.S.; Clifford Ko, M.D., F.A.C.S.; and Christopher Saigal, M.D., F.A.C.S. The ACS-SSR allows specialty societies and boards to use a common platform to aggregate clinical data. The ACS-SSR has moved forward with two surgical boards and societies targeting three "regulatory" items currently being used to assess individual surgeons: (1) Maintenance of Certification by the American Board of Surgery (and other Boards), (2) The Physician Quality Reporting Initiative by the Centers for Medicare and Medicaid Services, and (3) the Ongoing Practice Performance Evaluation by the Joint Commission. The individual surgeon will submit Maintenance of Certification data through the ACS-SSR to the American Board of Surgery. The American Board of Surgery will send feedback to the provider, which begins the learning cycle that is managed through subsequent data submissions to

Photo: J. P. Rathmell.

Accepted for publication March 15, 2012. The authors are not supported by, nor maintain any financial interest in, any commercial activity that may be associated with the topic of this article.

 Anesthesiology 2012; 117:929–30

This editorial is part of an editorial series on the emerging role of data registries in advancing clinically integrated medical practice.

the ACS-SSR. The ACS-SSR is scheduled for official use for Maintenance of Certification Part IV July 1, 2012 for case types in general surgery and colorectal surgery. As the ACS-SSR grows, additional content will be included in the Maintenance of Certification process, along with other societies and their boards.

It is helpful to understand that the ACS-SSR has a fundamentally different mission and architecture than the National Surgical Quality Improvement Program (NSQIP). Structurally, NSQIP is a hospital-based, risk-adjusted outcomes registry. The NSQIP has certified data entry and audit processes to ensure validity and reliability of the data. It is designed to improve quality and decrease complications and their related costs.[1] Hospitals subscribe to participate. Once subscription is secured, the hospital recruits a surgeon champion and a certified nurse for managing the local NSQIP participation. The case-log registry is available to members of the ACS as a benefit of membership. It allows surgeons to self-report and track their outcomes in a convenient and confidential manner. However, unlike NSQIP, the data in the case-log are not audited or risk-adjusted. It is an inclusive system targeted for use by the individual surgeon. The ACS-SSR-based case-log system will provide structure to a growing list of surgical specialty societies and their boards.

With the success of the AQI and the ACS-SSR, we have to ask if there is a role for combining the registry efforts to benefit the surgical patient. Anesthesiologists are now well positioned to participate in a collaborative registry because of the growth of the AQI. The pieces for the realization of the SQA's initial vision of a Surgical Data Registry are now intact. The ACS-SSR procedure menu could provide a road map for anesthesiologists to follow to include AQI perioperative data in a registry. ACS-SSR and AQI leadership can assemble work groups, consisting of anesthesiologists and surgeons, to develop content (variables) procedure-by-procedure, slowly developing core data. Experts from the ACS and the American Society of Anesthesiologists can work collaboratively to identify, develop, and define variables that are feasible and valid. The introduction of data analysis will support the evolution in reporting from crude rates to risk-adjusted rates.

This collaboration will help address gaps in care that exist for our surgical patients by sharing the data between surgery and anesthesiology. Currently, we are at the early stages of realizing this goal through the strategic relationship that has formed between surgery and anesthesiology at the SQA. Anesthesiology and the surgical subspecialties recognize the benefit of a collaborative surgical registry. Early action has begun to build a data bridge between our disciplines and professional organizations.

Many benefits will be realized when data from the pre-surgical clinic visits, perioperative care, and the postoperative surgery clinic continuum become harmonized. The scope of quality outcomes that we consider relevant for our surgical patients will expand with the availability of longitudinal surgical data. Rich opportunities for research will become available because of this collaboration. Patients will have access to meaningful reports to assist with their decisions on care. Health plans will have access to quality outcome measures established by physicians to create relevant performance reimbursement models.

There is much work ahead. How many of our patients currently have the ability to access procedure-specific performance records of their surgeon and anesthesia providers? Our future goals should include the use of "surgical" data to provide transparent reporting of meaningful measures that facilitate patients' care decisions, the creation of improvement cycles for anesthesiologists and surgeons that improve care and teamwork, and performance-based payment models based on physician-derived outcomes. Such meaningful data are the currency of heath care reform.

Frank G. Opelka, M.D.,* Frank A. Rosinia, M.D.†
*Louisiana State University Health Sciences Center, New Orleans, Louisiana, and American College of Surgeons, Surgical Quality Alliance. †Department of Anesthesiology, Tulane University, New Orleans, Louisiana. frosinia@tulane.edu

Reference

1. Hall BL, Hamilton BH, Richards K, Bilimoria KY, Cohen ME, Ko CY: Does surgical quality improve in the American College of Surgeons National Surgical Quality Improvement Program: An evaluation of all participating hospitals. Ann Surg 2009; 250:363-76