FOUNDATION FOR Health Care Quality

SURGICAL CARE OUTCOMES ASSESSMENT PROGRAM (SCOAP)

Advisory Board Minutes

Monday, March 28, 2022, 07:00-09:00

X	Bramhall, John; HMC	X	Kumar, Anjali: WSU	X	Schmidt, Zeila; Armus
	Capeheart, Raeann (Ann); Noridian	X	Kolios-Morris, Vickie; FHCQ	X	Thirlby, Richard; VMMC/FHCQ
X	Christante, Dara; Prov Sacred Heart		Loewen, Jason; Confluence Health	X	Transue, Emily; Health Care Authority
	Feldman, Tim; Capital Med Ctr	X	Mendenhall, Patrick	X	Weir, Ginny; FHCQ
	Fisher, Nancy; CMS	X	Nguyen, Thien; Overlake	X	GUEST: Kristin Sitcov, FHCQ
X	Flum, Dave; UW Medicine		Painter, Ian, FHCQ	X	GUEST: Jeannie Collins-Brandon FHCQ
X	Frankhouse, Joe; Legacy Good Sam		Porter, Allison; Skagit Valley	X	GUEST: Arman Dagal, Harborview
X	Gifford, Jonathan; Grays Harbor		Quade, Samantha; Prov. Everett	X	GUEST: Amir Bastawrous, Swedish
	Goldin, Adam; Seattle Children's		Rashidi, Laila; MultiCare Health Sys.		
X	Halpin, Valerie; Legacy Good Sam	X	Rush Jr, Robert; PH St. Joseph; **Chair**		
	Helton, Scott; Virginia Mason		Simianu, Vlad (Val); Virginia Mason		

I. Welcome, Introductions, Minutes

Quorum met.

Dr. Rick Thirlby, Medical Director, opened the meeting, introduced those who planned the meeting, and those present introduced themselves, their organization, and their interest in surgical care.

Action Item: October 2021 Advisory Board meeting minutes approved.

II. FHCQ Strategy

Ginny Weir, CEO, FHCQ, opened the meeting thanking those present, framing the intent of the day to focus on strategic planning, and the vision for equitable health care. She outlined the Foundation for Health Care Quality strengths and the organization's strategic priorities: equity lens, life-course perspective, growing impact, and involving those with lived experience.

III. Strategic Process

Jeannie Collins-Branden outlined why we will focus on strategic planning including: making good use of limited resources, ensuring we are providing value, ensuring that we are meeting why we exist, and to energize around a common vision and mobilize in a common direction. She discussed the plan for the next couple hours – needing to decide what falls within our scope, purpose statement, context map, strengths-weaknesses-opportunities-threats (SWOT), and where we can/want/are going and how we can get there.

Dr. Rob Rush, Advisory Board chair reviewed the CQIP agreement and proposed a working purpose statement, "*Surgical COAP is a regional quality improvement collaborative that leverages physician leadership and clinical data to establish and drive best practices in surgical care. Our purpose is to support all hospitals and clinicians in achieving the highest levels of patient care and outcomes*." Members added: term "drive" is vague and incorporating addressing inequity into the statement to reflect FHCQ goals. Purpose statement changed to "*establish and promote best practices and address inequity in surgical care.*"

Dr. Rush reviewed the history of the FHCQ and of Surgical COAP including the surgical checklist initiative, advent of Spine COAP, public reporting of data, strong for surgery, safe and sound campaign, and small bowel obstruction, and transparency within the collaborative. He then

outlined the environmental context in which Surgical COAP exists including feedback from members including:

- Healthcare trends: Caregiver burnout and staff shortages; Consolidation of systems and services; being reactionary vs. proactive approach to quality improvement especially because of COVID; Demands from multiple entities with separate but redundant QI processes; Lack of financial incentive for quality; Further decline in diversity, equity and inclusion; Difficult access to healthcare for those without employer-based insurance; Ongoing demand for data that demonstrates quality. Members added:
    - More demand for transparency especially with people having immediate access to health record.
    - Professionalization of clinical data reporting within systems that is making it challenging for homegrown work to find space when any outgoing dollar has to be tied to a requirement or accreditation or regulation.
- Political factors: After-effects and future uncertainties around the pandemic; Awareness of surgical waste and impact on climate. Members added:
    - Building of a new medical school on the east side of the state. This may be an opportunity.
- Economic climate: Squeezed hospital budgets; Public-facing accolades prioritized over patient care and outcomes; Hospitals are in a "chasing our tails" approach to funding, resourcing and payment/reimbursement for health care and quality; Lack of hospital resources for quality improvement; No alignment of payer policies. Members added:
    - What doesn't meet the needs of the hospital as a whole is left by the wayside.
    - Medicare push to include intensive care bundles was since rescinded and their general push to reduce cost.
    - Trying to centralize and standardize equipment. Impacts innovation.
- Technology factors: Uneven availability and training in robotics; Rise of EHRs (but difficulty pulling data from them). Members added:
    - New techniques in the hospital and struggling how to bring in safely and the criteria for a clinician to be trained. Often this is device-dependent.
- Customer Needs: Identification of best/innovative practices; Funding and leadership support for quality improvement; Effective process for moving from knowledge to practice; Actionable reports; Broader view of care/disease-based vs. procedure-based registry; More cost-effective ways to abstract data; Regional initiatives and collaboration; National benchmarking. Members added:
    - Still struggling to get return to function and long-term outcome data. Hospitals are not able to capture data as they return to their community. There is opportunity for an organization to take a disease-based, more person-centered data center.
- Competition: Vicious competition rather than cooperation in all facets of the industry, combined with rigid control of PHI; Systems competing for patients and contracts; Internal QI databases; NSQIP. Members added:
    - System-based databases such as through Providence, UW, etc. These are not very nimble and may not be helpful to front-line people.
    - Consolidation of EHR systems. There will be an Epic or Cerner product that is a quality database across systems.

Dr. Rush reviewed responses to the SWOT.

- Strengths: Clinician-led quality agendas, Grassroots; Large, rich clinical dataset-driven; Regional focus & comparisons; Nimble data capture; Mapping processes to outcomes; Regional benchmarking; Risk adjustment of outcomes; Tracking outcomes & adherence to standardized parameters; Skilled abstractors; Non-biased, collaborative.

- Weaknesses: Manual abstraction of data too costly; Insufficient communication of regional QI efforts; Too few regional initiatives; Unstable membership; Insufficient program funding, staffing, & capacity; Low visibility; Lack of engagement from hospital administrations; No authority to impact QI processes at hospital level; No alignment with NSQIP; Program relevance not established. Members discussed:
    - Transparency to the public as a weakness and an opportunity. Has not been incorporated into deep dives.
    - Payment systems from sites are not sustainable.
    - Cannot link data to claims.
    - Risk adjustment not reliable due to small numbers.
    - In our focus is on inequity we are limited on social determinants and post-discharge care.
- Opportunities: High demand for quality measurement & improvement; Align with NSQIP; Electronic abstraction; Produce actionable reports; Engage new members; Engage payers to secure funding support; Foster internal program champions at all sites; Look at SCOAP vs. non-SCOAP hospital outcomes to demonstrate value; Increase visibility; Increase partnerships/allies; Stratify metrics by SDOH, race/ethnicity, payer; Engage patients; Harness the energy and process of ACS Quality Verification Program; Capitalize on deidentified SCOAP datasets commercially; Disease-based registry; Focus on value/outcomes to cost ratios. Members discussed:
    - Broader use of Surgical COAP as a tool for education or research by all participating sites.
    - Laser-focus on addressing inequity. This is especially important for Medicaid and may make the program more attractive to the state.
- Threats: Some hospitals choose NSQIP over SCOAP; Hospitals are cutting budgets/difficult funding climate; Staffing shortages and burnout threaten engagement.

IV. SCOAP Today

Ms. Collins-Brandon shifted the focus to where Surgical COAP is going (e.g., bring more value to members, make sure the program is focused on the right things). Hospitals are the primary customer with needs some of which are met by surgical COAP some of which may be met by a competitor and make some attributes redundant. The competitive advantage is what the competition does not offer – we want to expand this area of perceived value and think about what else we can address or if there are actions we are doing that are unknown to our customers or actions we are doing that we should stop doing that are not needed by hospitals and our capacity to do more.

- Dr. Thirlby discussed an ask for data on perioperative normothermia that may not be seen by administrators but would be valuable as it shows compliance with guidelines.
- Surgeons are receiving individual data reports and are somewhat a customer.
- Ms. Collins-Brandon outlined how Cardiac COAP thinks about national registries as a competitor. When it became clear that the STS had momentum, Cardiac COAP committed to shift over to the national framework to not be redundant with national systems and use that data to change practice. Less about creating a unique database. Not necessarily comparing your site to another site, it is about both of you improving.

VI. Competitive Strategy Exercise

Ms. Collins-Brandon led an open discussion on what hospitals unmet needs may be. Members discussed:

- We can change and improve care through initiatives such as Strong for Surgery. We are active rather than passive. We need to emphasize this more as a competitive advantage and eliminate variation better then NSQIP.
- Many advisory board members are at hospitals that no longer use surgical COAP or don't know if they do. This is a huge issue that champions can't make a case within their site. We have moved away from changing behavior (e.g., we are part of X initiative to change indications for Y surgery). A lack of ability to articulate the competitive advantage is an issue.
- We don't have a standardized place in each site's hospital's program where a champion can use the data. No dashboard to look at trends and act.
- Unmet need to find quality champions.
- Worth knowing what happens to NSQIP reporting – if you are not an outlier it goes from inbox to outbox, 95% of hospitals are not outliers for anything. Even in a NSQIP program this is inefficient. If we only worked on items that could make change – could do cross sectional look at last 100 cases then pick another topic. Regional roving quality collaborative. NSQIP can't do this.
- Can we link our data to claims data. CHARS lags a year and we have linked to this database – it is a research project not a tool to improve efficiency. The All Payer Claims Database could be a tool – it is not free.
- The neutral, unbiased and inclusive environment is a competitive advantage. NSQIP has 700+ hospitals and has a rural module. The checklist campaign felt good.

VII. SCOAP in 2-3 Years: Big themes into draft strategic priorities

Members broke into subgroups to visualize that its 2025 and Surgical COAP is thriving and considered what membership looks like, services that we provide, how we are perceived by members and stakeholders, and operational improvements that have been made. Subgroups reported:

- Granular details of where we are making mistakes is useful.
- Higher-level data is important for administrators who are decided whether to pay for program.
- FHCQ as an aggregator of data. Do we need to have a core data set? Focus shifts every six months to improve a facet of clinical care. Use audits to improve rather than own dataset.
    - UW and PeaceHealth both subscribe to NSQIP. Providence has own system – are they defining the variables the same? Probably only 3-4 other databases and some without that can use the Surgical COAP database.
    - How to create a business model around this aggregator model. Are hospitals still paying for this? We have never had great success getting payers to pay. Open up targeted focused quality-improvement such as around readmission. This might require a different generation of surgeon-leaders.
    - Methodology differences between NSQIP and Surgical COAP. We collect data on everyone who gets an appendectomy or colectomy. They do a small number of all procedures. NISQIP was meant to find signals where the need for QI would exist. Not collect data on all patients. There are disease-specific registries like for colectomy and some sites do this. Surgical COAP originally wanted to focus on process and improving process. Every dollar spent on collecting appendectomy cases that we don't do anything with is a dollar wasted.

- Surgeons can't describe the structure of quality within their hospitals. Opportunity for surgical CVOAP to help identify and articulate appropriate QI structures and models for their sites.
    - Surgeon leaders need the tools to create action. Can provide tools.
    - Empower surgeons to be leaders.

Jeannie summarized that a strategic priority might be promoting practice transformation rather than data capture. Members listed:

- Changing clinical practice with a laser focus on a facet of care at the state level. Step one can be showing a difference. Need to shift from the focus on data, paying a lot of money to ARMUS, getting reports that aren't doing anything. We have lost some of the original enthusiasm and focus.
- Decide what we are going to stop doing – what is wasteful.
- Collaborate with the Hospital Association on data. Physician participation is key. No other database has this. Build partnerships.
- Identify secure and reliable funding.
- Produce a report on outcomes by payer. Once you see it you can't un-see it.
- Recruit next generation of leaders.
- WSU medical school focused on inequity and especially rural care improvement. Opportunity here.

VIII. Meeting adjourned.