



SCOAP Saves Hospitals Money

SCOAP improves quality by defining, tracking and creating tools to drive changes in surgical care. SCOAP has modest associated costs in yearly fees (\$1-9K) and data abstractors/extractors (\$10-20K, depending on hospital size and EMR capacity). At a time when financial resources are limited, why should hospitals spend money on SCOAP, and where is the value for their investment?

Most hospitals get paid for an episode of surgical care through the Diagnosis Related Group (DRG) prospective payment system (APR-DRG or MS-DRG). The DRG reimbursement pays for an “average” episode of care which encompasses procedures, medication and length of stay.

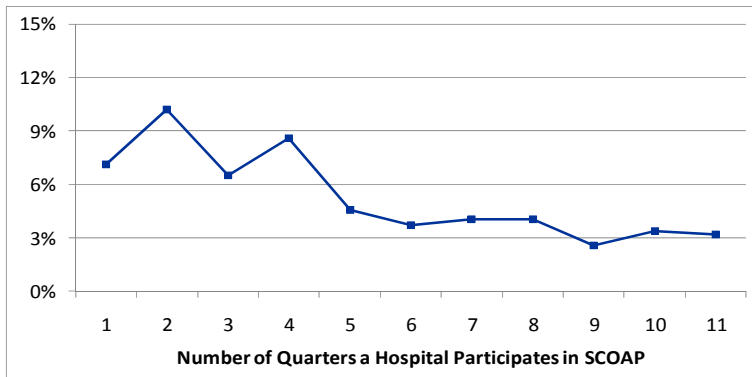
The profit margin per surgical case improves by: 1) Reducing excess costs of care due to complications/reinterventions; 2) Shortening length of stay; 3) Decreasing the use of expensive drugs; 4) Increasing adherence to reimbursement-linked metrics and; 5) Increasing standardization of routine care.

How SCOAP impacts these 5 profit areas:

I. Reducing excess costs of care due to complications/reinterventions

A recent study of over 1000 patients (Dimick et al) demonstrated that, when there were complications in surgery, hospital profit margins decreased 3-23%. SCOAP hospitals reduced the rate of expensive operative reinterventions after colorectal surgery from 7.1% to 3.2% during the first 2 years of participating in SCOAP. The key in achieving this goal was the fact that SCOAP uses a “bottom-up approach” (surgeons and anesthesiologists work together examining the data and deciding on ways to improve care).

Figure 1. Rates of reoperative complications after colorectal resections among SCOAP hospitals, by quarter of SCOAP participation



2. Shortening length of stay:

Reducing complications means reducing the length of stay. Surgeons at many SCOAP hospitals have worked over the past 3 years to drive down length of stay (Figure 2). This will be an expanded focus of surgeons and anesthesiologists at all SCOAP hospitals in 2009 and will include reducing length of stay due to postoperative nausea and vomiting, which is particularly important for profit margin among patients having outpatient surgery.

Figure 2. Reduction in length of stay for elective colorectal resections at SCOAP hospitals. The majority of SCOAP hospitals show a decreased length of stay over time – some had dramatic improvements.

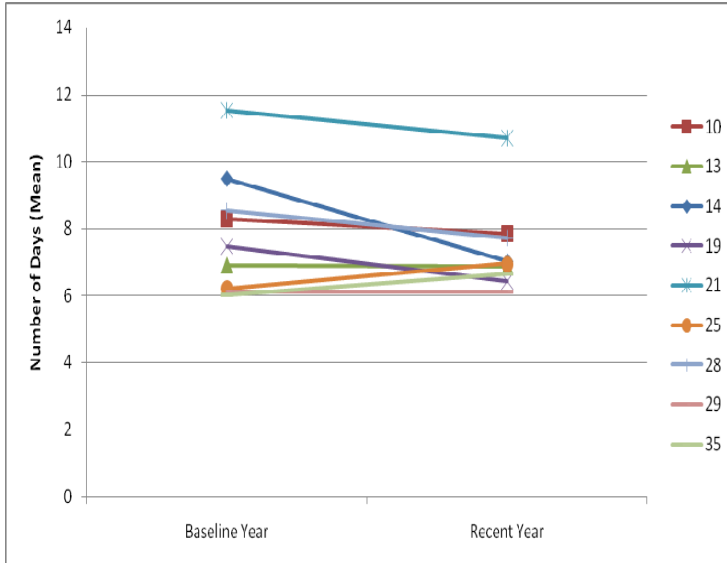
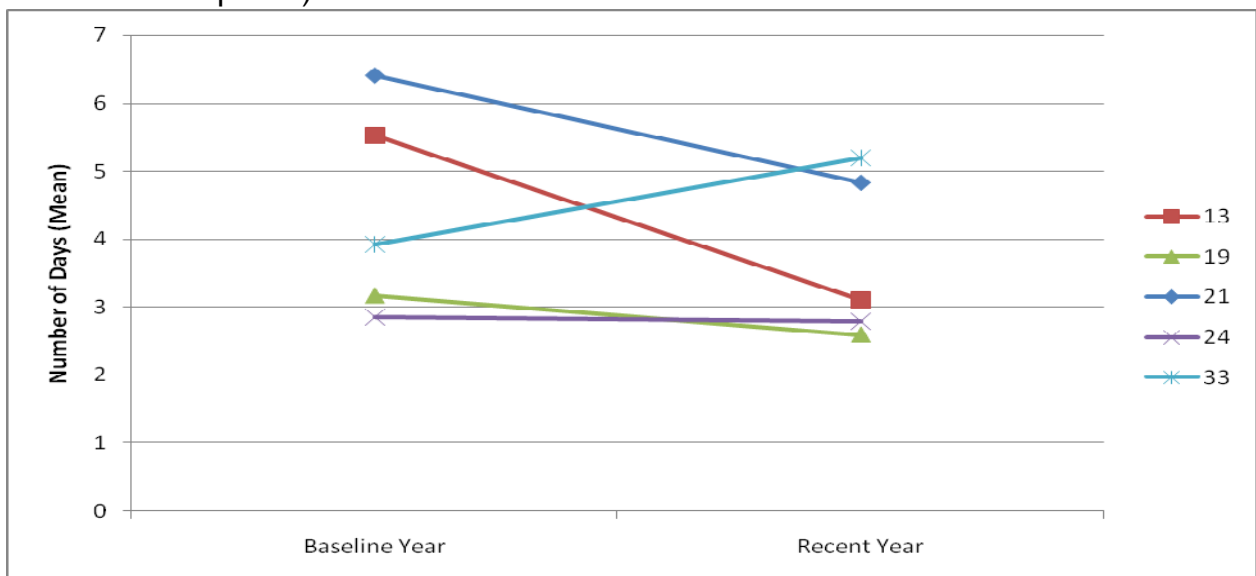


Figure 3. Reduction in length of stay for elective gastric bypass operations at SCOAP hospitals. The majority of SCOAP hospitals show a decreased length of stay over time -some had dramatic improvement (the outlier hospital had complete turnover of the surgical staff during the observation period).



3. Decreasing the use of expensive drugs:

SCOAP is planning a major initiative in 2009 to reduce the use of more expensive (sometimes non-generic) medication alternatives in surgical care and to more critically evaluate new and emerging medications (e.g., Entereg, Aloxi). The use of more expensive alternatives and emerging medications cuts directly into hospital profit margins per DRG payment. While hospital’s P&T committees have been working to both regulate new drugs on formulary and encourage less expensive alternatives, there are many commercial forces working against this. Data-driven, clinical community-led change in prescribing behavior will support the hospitals in their efforts to optimize profit margins.

4. Increasing adherence to reimbursement-linked metrics:

Another important source of profit is through adherence to reimbursement-linked metrics. These include a) Medicare’s 2% increase in reimbursement if **core measures** are successfully reported (for surgery, that means the successful reporting of SCIP measures); b) for hospitals that employ surgeons, physician-level quality reporting (**PQRI**) and value-based pay for performance will likely be an increasing source of revenue; c) Medicare will no longer allow extra billing for “**never events**” (such as infections in bariatric surgery); and d) some insurers will **not pay hospitals for readmissions** within a certain number of days of discharge. While some of these reimbursement linked metrics are achievable with simple system changes, others require real clinical buy-in to create changes in physician behavior. Hospitals have been trying for many years to involve surgeons more effectively in addressing all these measures with varying success. SCOAP is a surgeon-led program that actively engages surgeons in making necessary changes in clinical behavior. A bottom-up approach capitalizing on community ownership of these metrics will be more effective.

A. SCOAP helps achieve the successful reporting/performance of SCIP measures through the surgeon-led SCOAP Surgical Checklist Initiative (www.surgicalchecklist.org). Engaged clinicians perform better than non-engaged clinicians on most QI metrics, and SCOAP hospitals perform better on SCIP metrics than non-SCOAP hospitals.

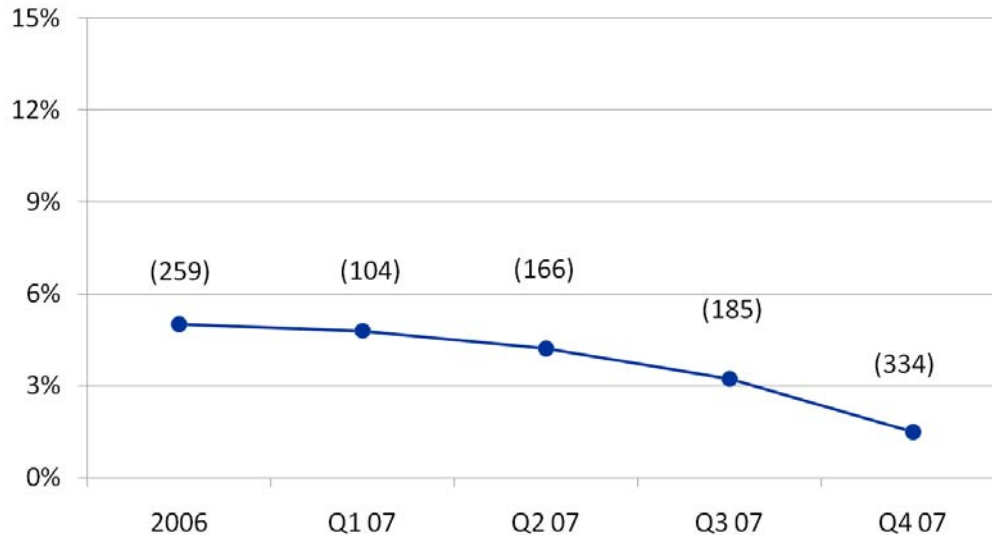
(Table I)

	SCOAP Hospitals	Non-SCOAP Hospitals
Antibiotic Before Incision	90.86	86.02
Correct Antibiotic for Surgery	95.64	94.56
Antibiotic Stopped After Surgery	85.86	84.36
Blood Clot Prevention	83.42	82.07
Dr. Ordered Blood Clot Prevention	85.36	84.51

B. SCOAP helps achieve PQRI metrics through the surgeon-led SCOAP Surgical Checklist Initiative.

C. SCOAP surgeons decrease the number of “never events” like surgical site infection in bariatric surgery through tracking and benchmarking against colleagues. For example, at SCOAP hospitals rates of infectious complications among patients having bariatric surgery decreased considerably (Figure 4). Since hospitals will no longer be able to charge for these infections, SCOAP-driven reductions increase profit margin.

Figure 4. Rates of operative reinterventions for infectious complications in bariatric surgery (now a never event) at SCOAP hospitals



D. SCOAP is working on reducing readmissions by benchmarking and evaluating reasons for readmission at each SCOAP hospital in 2009. The reduction of readmission is a strategic focus of SCOAP for the upcoming year.

5. Increasing standardization of routine care:

“Routine”, daily blood testing after surgery offers little to most patients, costs hospitals money and cuts into profit margins. While the “right” number of blood tests after surgery is a matter of debate SCOAP surgeons are working as a community to monitor the frequency of blood tests after surgery and to benchmark off best practices across the state. Daily blood testing for a routine surgical hospitalization can add up to \$1000 to the cost of a procedure to the hospital. In the future, SCOAP surgeons will be exploring other areas of standardization that the clinical community can rally around, highlight with SCOAP monitoring and then impact through collaboratives such as wound care, instrumentation and implants.

These are some of the ways that hospitals save money by using SCOAP, and why a small investment in SCOAP will help deliver safer, higher quality care and will also provide return on investment. Using the SCOAP newsletter and web-based SCOAP communication programs (<http://www.scoap.org/clinicians/community.html>), we will be expanding on each of these points during the upcoming year and will provide additional cost data back to the hospital community so they can better see the value of being part of the SCOAP community.