SCOAP
SURGICAL CARE AND OUTCOMES ASSESSMENT PROGRAM
A PROGRAM OF THE FOUNDATION FOR HEALTH CARE QUALITY

The SCOAP Box

"Sharing Progress – Driving Excellence"

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In This Issue

The SCOAP Community Speaks Up

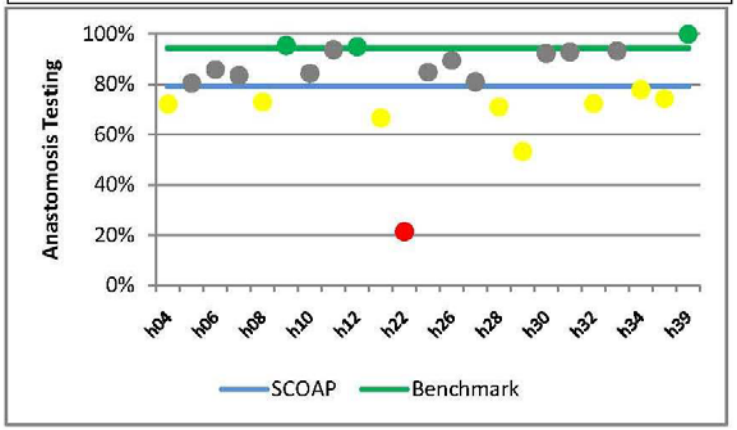
We were asked by surgeons at Good Samaritan Hospital in Puyallup, "Why is SCOAP looking at leak testing? Aren't there risks associated with that?" (http://www.scoap.org/clinicians/community.html#Leak)

Testing a reconnected colon in the same way we test a repaired tire is a simple, common sense intervention aimed at reducing leaks. It lets you find a leak in the OR when it can be fixed with little impact, instead of on day 2 or 3 when our patients are so sick that the only way to help them is a colostomy (often not reversed), days in the ICU, infections, and

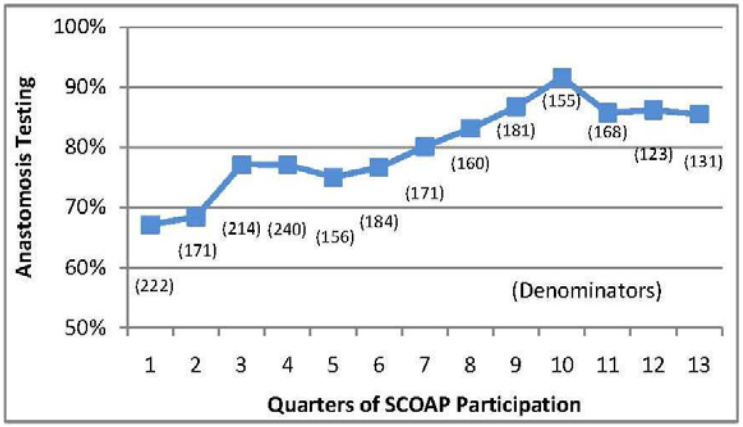
SCOAP is the future of surgical quality improvement. It is a physician-led, voluntary collaborative creating an aviation-like surveillance and response system for surgical quality. SCOAP's goal is to improve quality by reducing variation in process of care and outcomes at every hospital in the region.

SCOAP Making a Difference

Hospital variation in the rate of anastomosis testing among elective left and low colon/rectal procedures, Q1 2006 – Q1 2009.



Anastomosis testing among cases of elective left and low colon/rectal procedures, by quarter of SCOAP participation.



For more on anastomosis testing, please see The SCOAP Community Speaks Up column to the left. To learn which hospital is yours in the slides above, or to ask questions about your data report, please contact Rosa Johnson at (206) 682-2811 x 20 or rjohnson@qualityhealth.org.

SCOAP Annual Retreat Summary – June 13, 2009

The second annual SCOAP retreat was held on June 13, 2009, in conjunction with the Washington State Chapter of the American College of Surgeons annual meeting, at Campbell's Resort in Lake Chelan, WA. 53 SCOAP surgeons, data

hernias. It is true that many leaks happen in a different time course – perhaps there was not an apparent leak in the OR, but the reconnection broke down over time – but for the subset that really do have a leak in the OR (only known if you test) this is a low cost, low hassle approach to detection. Unfortunately, the financial incentives for testing are not perfectly aligned to increase testing. A provocative test to confirm anastomotic integrity – air inflation or methylene blue instillation through a tube or scope – is not a separately billable part of a colon or gastric anastomosis. However, when endoscopes are used at the start of a procedure as part of the planning for an operation (e.g., restaging for cancer, planning for a resection), it is separately billable, and because it is now in the OR and open, the same scope could also be used at the end of the operation to check on anastomotic integrity. Many surgeons view leak testing as a simple add-on to the case and part of something for which they are already charging (the pre-op scope).

So why would SCOAP have to chase this metric? Why isn't it 100% and what is it going to take to get us there? When we started SCOAP testing of left-sided colon, anastomosis was hovering around 50%, although some of this may have been under-reported in operative notes – but given the "billability" of the scope, it is hard

abstractors, quality improvement professionals, and SCOAP staff members came together to celebrate SCOAP's achievements of the past year and to engage in important strategic discussions regarding plans for the upcoming year.

Governor Christine Gregoire welcomed participants to the meeting. Keeping SCOAP vital was a core theme of the day, and discussion with the SCOAP community revolved around new metrics, new reporting formats, and expanded SCOAP focus. SCOAP Medical Director Dave Flum reviewed the activities of the past year, which included adding 21 new hospitals to the SCOAP roster, launching the SCOAP Surgical Checklist Initiative, offering surgeons a way to fulfill their MOC Part 4 requirements, and beginning work on several new modules (for more information on SCOAP's activities during the past year, **click here**) (**http://scoap.wordpress.com/2009/06/13/scoap-annual-retreat-year-in-review/**).

Four SCOAP hospitals (PeaceHealth St. John Medical Center, Longview; Skagit Valley Hospital, Mount Vernon; Swedish Medical Center, Seattle; and Valley Medical Center, Renton) shared SCOAP successes at their hospitals. Dr. Sean Sullivan, Professor in the Schools of Pharmacy and Public Health/Community Medicine at University of Washington, gave the keynote address and outlined the business case for SCOAP and how SCOAP can show return on investment to hospitals (for more information on Dr. Sullivan's presentation or to see his PowerPoint slides, **click here**) (**http://scoap.wordpress.com/2009/06/13/scoap-annual-retreat-making-the-business-case-for-scoap/**).

The discussion on the business case for SCOAP will be critical to the future growth and development of SCOAP and informed the afternoon sessions at the retreat. Break-out sessions examined the issues of post-operative nausea and vomiting, discharge DVT prophylaxis, and higher/lower risk SCOAP modules. Data abstractors and QI personnel also had the chance interact in order to learn from each other, to communicate issues from the past year at their hospitals, and to share best practices and tips for ensuring high-quality data.

We are looking forward to an exciting and highly productive coming year and hope to see you at next year's retreat, details to be determined and announced in a future edition of The SCOAP Box.

"I have been excited about SCOAP since I first heard about this new, grassroots effort to finally address the way we take care of our surgical patients. SCOAP brings the hope of eliminating anecdotal, often fragmented, often unmeasured surgical care. "The way we have always done it" will quickly be replaced by "this is the way we are now measuring and implementing surgical best practices in our state". I am wearing my SCOAP surgical cap with a smile that we surgeons are leading this effort with a passionate commitment to quality care. Count me in and fully engaged." –David R. Byrd, MD; General Surgeon, University of Washington Medical Center

to say. Here is what we heard when we started: some surgeons said they don't like to add the time to the case; some believed that stressing an anastomosis can weaken it and actually cause leaks; many said that in cases when there was a leak after surgery, the leak test had been normal and therefore the test did not prevent a leak. And always the question was, while it seems like common sense, where is the evidence that leak testing makes a difference?

To see the rest of this answer, **click here (http://www.scoap.org/clinicians/community.html#Leak)**.

Visit the **SCOAP website (http://www.scoap.org/clinicians/community.html)** for answers to other questions raised by members of the SCOAP community.

Contact Us

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SCOAP's Summer Project

TACKLING THE TASK OF DELIVERING HIGH-QUALITY AND COST-EFFECTIVE CARE

This summer SCOAP is launching a pilot project at three hospitals that expands its unique model of clinician-led system change to include feedback on efficiency of care. SCOAP surgeons at Good Samaritan Puyallup, Providence Everett and the University of Washington Medical Center will be focusing on three areas identified as having significant impact on the cost effectiveness of care:

1) Pre-operative testing that is not actionable and unbillable;
2) The use of expensive OR supplies when a therapeutically equivalent but less expensive supply can be substituted; and
3) Assessing the effectiveness of expensive drugs and implants.

The SCOAP team will help hospitals hit that sweet spot between delivering optimal care in the most cost effective manner. For more information on this expanded SCOAP, please contact Justine Norwitz at **jnorwitz@qualityhealth.org** or (206) 399-2621.