Surgeon Scorecard offers transparency, creates a path for improved care

ProPublica’s recent surgeon quality scores may not be perfect, but the effort is a step in the right direction

The nonprofit news organization ProPublica has never been one to shy away from controversy, particularly when it comes to healthcare quality. In the past, it has published databases in which patients can see whether their doctor is taking money from pharmaceutical companies, and what medicine he or she is prescribing as a result.

In July, the news organization took another shot at tearing down the barrier between patients and healthcare organizations. This time, it targeted surgeons. With help from two dozen physicians, along with Medicare billing records from 2009 to 2013, ProPublica created the “Surgeon Scorecard” (https://projects.propublica.org/surgeons), which exposes complication rates for more than 16,000 individual surgeons operating at more than 3,500 hospitals.

Although many within the medical field celebrated this new step in transparency, the Scorecard has become relatively contentious, particularly because it unabashedly calls out surgeons based on their performance, both good and bad. ProPublica restricted its analysis to eight low-risk elective surgeries performed on healthy patients, but the organization was criticized for relying largely on unreliable readmission data to determine complication rates. Critics also argued that Medicare data represented a limited number of surgeries.

In particular, Peter Pronovost, MD, senior vice president for patient safety and quality, director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine in Baltimore and a leader in the field of patient safety, told ProPublica the measures were not valid since the Scorecard fails to account for the variation within patient readmissions.

Patient Safety Monitor Journal spoke with three of the country’s leading patient safety experts to get their reactions to the Surgeon Scorecard and how the data could impact transparency and quality initiatives at the provider level.

(Editor’s note: Some responses have been lightly edited for space and clarity.)

Q Do you believe the Surgeon Scorecard is an effective and fair way to measure quality care?

Joe Kiani, founder of the Patient Safety Movement Foundation (http://patientsafetymovement.org): I believe it’s a great step forward. ProPublica seems to have done a thoughtful job on how to rate surgeons of elderly patients, and it certainly should help detect surgeons that are outliers, good and bad. That alone is a huge service to patients.

Ultimately, hospitals should be volunteering this information and more to create transparency and healthy competition for the betterment of patients.

Tejal K. Gandhi, MD, MPH, CPPS, president and CEO of the National Patient Safety Foundation (NPSF) in Boston: I believe it is a step in the right direction. The Surgeon Scorecard is not perfect, but I believe the reporters, by soliciting advice and input from researchers in the field, really did the best they could to risk-adjust and show the most accurate picture possible. More transparency is better than none. They also acknowledge the limits of the data that they used, so it is important to note that as well.

(Editor’s note: Gandhi wrote about the Surgeon Scorecard in a blog post: http://npsf.site-ym.com/blogpost/1198150/224318/When-We-Share-Data-Patients-Win.)

Robert M. Wachter, MD, professor and interim chairman of the department of medicine, and chief of the division of hospital medicine at the University of California, San Francisco (UCSF): The devil’s in the details, but I think it’s an important concept, and I think we have to do this kind of measurement. The science is still a little bit rudimentary, so there are some flaws, but it’s about as good as we can do today, and I think
by virtue of doing this kind of thing, it will drive this process and get better over time.

Q From a public health/patient safety perspective, how important is it to be transparent with surgical outcome information?

Kiani: It is critical. Full transparency is the only way we will eradicate preventable deaths in hospitals.

Gandhi: From a patient safety perspective, we at the National Patient Safety Foundation feel this is extremely important, but not so we can point fingers or punish people. What needs to come out of this is learning: Why do the high performers have such low complication rates? What do they do that others don’t? And how can we standardize the practices of the high performers to raise everyone’s outcomes to better levels, improving care and outcomes? That’s how I’d like to see these data used.

Wachter: I think the experience so far has been that putting out information about quality or safety or patient experience at the level of hospitals, health systems, or doctors has worked better than people thought, has motivated more change than people thought, and it’s probably inexpensive when you think about other potential ways of doing it, like changing the payment system.

What is interesting is there is not a whole lot of evidence so far that a huge number of patients are going onto these websites, whether it’s hospitals or doctors, and really basing their decisions on where they go on what they see. And yet it seems like probably some combination of shame and pride among doctors and healthcare administrators does seem to be enough to move the needle.

I can tell you, at the medical center level, our data that is reported on Hospital Compare, it’s not clear that data really influences whether a patient in Marin County will come to UCSF or a different hospital. But I can tell you, we look at it a lot, and we pay a lot of attention to it. When we’re not doing well, it motivates us to improve and develop a program in ways that are greater than I expected when all of this started 10 or 15 years ago.

What we’ve learned is: Transparency is both the right thing to do for patients to help them make decisions, but it’s also very powerful and a relatively inexpensive tool for getting systems to get better at what they do.

Q Some have criticized the scorecard because it paints an incomplete picture. Others argue that any information is good information. Which side do you fall on, and why?

Kiani: Any information is good information. Leapfrog and Hospital Compare were good steps; this is another good step. I commend ProPublica on being part of the solution and looking for ways to inform the public.

Gandhi: NPSF’s Lucian Leape Institute published a report earlier this year, Shining a Light: Safer Health Care Through Transparency (available at www.npsf.org/transparency), which argues for greater openness at all levels of healthcare, so we definitely fall on the side of more rather than less information. But raw data often require analysis and interpretation, and that is what I believe ProPublica tried to do in their report.

As I said, the reporters acknowledge the limits of these data—that they narrowed their analysis to certain procedures; worked from Medicare billing records, not clinical outcome data; and excluded surgeons with very low volume in some procedures. The unfortunate thing is it shouldn’t be this hard. We shouldn’t have to rely on an outside news organization to shine the light on these kinds of issues. We need Medicare, private payers, and healthcare systems to help move the needle on greater transparency.

Wachter: “Up until recently, measurement has been at the health system or hospital level. Then you have the issue that a hospital is getting dinged on Hospital Compare, and the hospitals have to engage the doctors. That’s happened a lot over the last 10 years, and that’s been healthy because it’s created an environment where we know we’re in it together. When you’re dealing with these measures and you’re
not doing well, it’s not like a hospital CEO can snap his fingers and things get better—clinicians have to be engaged, and everyone has to recognize that we’re part of the same team.

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Now, the flip side is happening. We’ve come to realize very quickly that surgeons aren’t operating in a vacuum. A surgeon’s outcomes have a little bit to do with his or her technical skill, but probably more to do with the state of the system. How good is teamwork? How well do they use checklists? If you’re looking at readmission rates, what does the discharge system look like? Do patients get a phone call after discharge to see how they are doing? Those are things that often beyond the capacity of the individual surgeon to do.

So now we’re going the other direction where surgeons are beginning to say, “I didn’t look good on this measure, and a big part of the way to make it better is the system that I work in has to do better.” So they are now calling the hospital CEO and saying, “You need to help me improve my outcomes” in the same way it was the CMO calling the surgeon five years ago saying, “You need to help us improve outcomes.” At the end of the day, that’s very healthy because these are not separate teams. If you’re going to deliver high-quality and safe care, it has to feel like there is some integration, where the CMO, CEO, physicians, and nurses are all going in the same direction.

Q Do you think this scorecard is fair to surgeons?

Kiani: Only time will tell. Surgeons who have been unfairly scored low will eventually voice their concerns, and hopefully the scorecard will be improved. It’s important to note that looking at 30-day readmission gives patients and payers part of the picture. But, like infant mortality tests, it doesn’t tell you anything about long-term quality of the care the patients received from their surgeon.

Gandhi: I think the reporters made a very sincere effort to be as fair as they could be. Unfortunately, risk-adjusting is an imperfect science. I would love to see the day when healthcare professionals are partnering with the media to really help translate this information to the public in a way that anyone can fully understand the implications and limits.

Wachter: There’s no way around the fact that these will be controversial and on some level probably a little bit unfair, but to me, the greater-good question is: Is the world a better place with this thing out there or not? To me, it is, because I think if I were a patient that was trying to figure out where to get one of these elective procedures, if I try to sort that out today without scorecards like this, I have no idea. I’m sort of guessing.

I’m an insider. I’m an expert. People call me and say, “My uncle Joe needs to get his knee replaced in Charlotte; who should he see?” I’m on the Web and looking at people’s résumés to see how many articles they’ve published, which doesn’t have anything do with how good they are as a surgeon, or where they went to med school. What does that have to do with anything?

So, I’m an insider and I don’t have any information on which to make these decisions. There are probably problems with it. There are surgeons that are categorized in this method in a way that is somewhat unfair to them, but directionally I think it’s correct. And I think that if I were a patient, I’d want to know this as opposed to knowing nothing, and by putting this out there, it drives the system to this debate, the debate we’re having now. You drive further measurement to be better and more accurate, you drive surgeons to think about their outcomes in new ways, and you drive health systems to think about supporting the surgeons and the teams in new ways—and I think overall, you make the world a better place.