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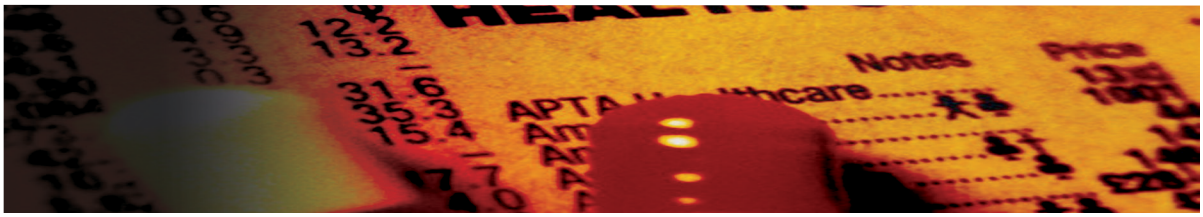
Issue 4



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IN THIS ISSUE

The paper "Complications and Failure to Rescue After Inpatient Noncardiac Surgery in the Veterans Affairs Health System," co-authored by Nader N. Massarweh, M.D., MPH, first appeared in JAMA Surgery online in September 2016. Massarweh is an assistant professor of surgery in the Division of Surgical Oncology at the Michael E. DeBakey Department of Surgery at Baylor College of Medicine and an investigator in the Center for Innovations in Quality, Effectiveness and Safety at the Michael E. DeBakey Veterans Affairs Medical Center. He is a fellow of the American College of Surgeons.

Baylor College of Medicine

RICE UNIVERSITY'S BAKER INSTITUTE FOR PUBLIC POLICY

HEALTH POLICY research

Rice University's Baker Institute for Public Policy-Baylor College of Medicine
Joint Program in Health Policy Research

Has the quality of surgical care in the Veterans Health Administration improved over time?

"Yes," says Nader N. Massarweh, M.D.

The recently issued final rule on the Medicare Access and CHIP Reauthorization Act will soon bring value-based payment models to the private sector. However, the U.S. Department of Veterans Affairs (VA) already has a long track record of focusing on value through a number of well-established programs to ensure that veterans receive high-quality care. Nowhere is this more apparent than in VA surgical care. Since the early 1990s, the VA Surgical Quality Improvement Program (VASQIP) has been a benchmark for national quality improvement (QI) efforts in surgery. Since its implementation, perioperative mortality and morbidity rates have significantly decreased and continue to decline. A recent study evaluating VA perioperative outcomes across a variety of surgical specialties found that rates of complications, mortality and failure to rescue (i.e., mortality after a post-operative complication) decreased over the last 15 years.

Failure to rescue has recently become a nationally endorsed quality indicator. It is a more appealing measure than morbidity alone for two reasons. First, complications are not always preventable, but when they do occur, early and appropriate treatment is crucial to ensuring the best possible outcome for the patient. Second, early recognition and treatment of complications represent actionable processes of care for QI efforts. As such, the observed decrease in failure to rescue rates suggest that VA hospitals understand this dynamic and are appropriately focusing on patients at these critical points in their care.

The VA continues to endure intense scrutiny in all aspects of care to veterans. But the VA's improvements in post-operative outcomes mirror similar trends in the private sector. As such, this study adds to the extensive body of literature suggesting that the VA provides care that is at least comparable to, and in many cases surpasses, that provided to patients in other settings. Furthermore, as the concepts of value and quality become more integral aspects of physician and hospital reimbursements, many of the VA's QI efforts likely can be used as templates for programs that could be successfully deployed in the private sector. A prime example is the American College of Surgeons National Surgery Quality Improvement Program, which was designed and implemented using VASQIP's blueprint.

Some critics suggest that veterans might be better served if they received health care from the private sector. However, two important points are often unacknowledged in such debates. First, the VA is the largest national integrated health system in the U.S. with standardized electronic health records accessible to all VA providers and compatible across all hospitals — something not currently available in the private sector. Second, veterans constitute a unique group of patients with specific health care and social needs. Taken together, these factors would likely make it difficult for the currently disjointed U.S. health care system to fully address the demands of caring for veterans and simultaneously and consistently duplicate the VA's outcomes. In fact, the private sector could perhaps learn important lessons from the VA in this era of alternative payment models and value-based payment.

HEALTH POLICY research presents a summary of findings on current health policy issues. It is provided by Vivian Ho, Ph.D., James A. Baker III Institute Chair in Health Economics and director of the Center for Health and Biosciences at Rice University's Baker Institute for Public Policy, in collaboration with Laura Petersen, M.D., MPH, chief of the Section of Health Services Research in the Department of Medicine at Baylor College of Medicine.

This publication aims to make research results accessible to regional and national health policymakers. The views expressed herein are those of the study authors and do not necessarily represent those of the Baker Institute or of Baylor College of Medicine.

The Baker Institute and Baylor College of Medicine's Section of Health Services Research work with scholars from across Rice University and Baylor College of Medicine to address issues of health care — access, financing, organization, delivery and outcomes. Special emphasis is given to issues of health care quality and cost.

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