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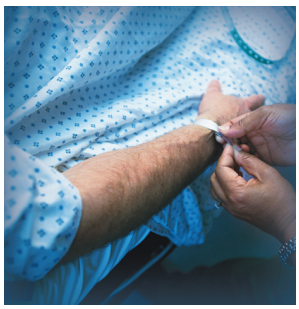
REPORTS

A new program in Washington state aims to boost patients' nutrition, monitor their blood sugar, help them quit smoking and document their medications before surgery—all to improve outcomes.

Strengthening patients for surgery

By TANYA ALBERT HENRY



Physicians have seen numerous shifts and tugs in hospital protocols in recent years, geared toward achieving better outcomes and eliminating infections after surgery. Now a statewide effort is targeting what patients do before they walk through that hospital door.

STRONG FOR SURGERY USES simple checklists that single out four areas for patients and physicians to evaluate in preoperative visits and, if needed, improve before an upcoming elective surgery or flag as an area to be extra cautious about when they are in the hospital. (See page 3 for the four areas.)

For example, is the patient getting proper nutrition? Is her blood glucose under control? What medications—from prescriptions to herbal supplements—is he taking that could adversely affect the surgery? Does the patient smoke?

Peer-reviewed studies have shown that a patient's risk for a negative outcome—ranging from infections to hospital readmissions—after surgery is lessened when any one of the four areas are managed before the patient is on the operating table.

Better nutrition and normal blood sugar can reduce infection complications. One study showed that when patients used a specialized nutrition formula, infectious complications were reduced by 40% to 60%.

Quitting smoking can reduce the risk of pulmonary complications.

Even changes made just weeks before surgery can make a difference.

Thomas K. Varghese Jr., MD, MS, director of thoracic surgery at Harborview Medical Center in Seattle, is Strong for Surgery's medical director.*

He said physicians and others at the hospital have been intent on better controlling what happens at the facility so patients have fewer infections and readmissions after surgery. But meanwhile, "We have no idea what happens to patients [that could impact surgical outcomes] from the time they sign up to see us until they are in the operating room."

That's exactly what Strong for Surgery is trying to alter. The program is not a research project, he stressed, but rather a vehicle to implement already known science.

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*WSMA supports the Strong for Surgery program. Dr. Varghese will speak about Strong for Surgery at the WSMA annual meeting, Saturday, September 28 at 3:30 p.m. at the Davenport Hotel, Spokane. See insert inside this issue.

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2013 WSMA Annual Meeting 4-page insert

Staff changes at WSMA

KATHRYN KOLAN, JD, was recently named the WSMA's director of legislative and regulatory affairs. Katie will lead the Olympia team and is responsible for integrating the association's policy and public advocacy programs with legislative and executive branch activities of the state and federal governments.

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The program is in sync with a national push for higher quality and lower health care costs in the United States, and it comes at a time when payers are increasingly reimbursing physicians and hospitals based on outcomes rather than volume.

It grew out of the existing Surgical Care and Outcomes Assessment Program, a physician-led, voluntary collaborative that took lessons from aviation— notably routine, detailed checklists—to create a surveillance and response system for surgical quality. More than 50 Washington hospitals participate in SCOAP, which began in 2006. Bad outcomes occurred about 18% of the time according to data collected between 2000 and 2003, pre-SCOAP. Following SCOAP's implementation overall adverse rates stood at about 9%. The health system saved an estimated $67 million in 2009, according to a clinical review in the journal Surgery in February 2012.

> Much effort has been expended to more strictly control what happens at the surgical facility so patients have better outcomes. But doctors "have no idea what happens to patients [that could impact surgical outcomes] from the time they sign up to see us until they are in the operating room. Strong for Surgery aims to change that."
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> *Thomas K. Varghese Jr., MD, MS, director of thoracic surgery at Harborview Medical Center in Seattle and Strong for Surgery's medical director.*

"We could sit back and say 'We've done a great thing,' or we could say 'We can do better,'" commented Dr. Varghese, who also is an associate professor in the division of cardiothoracic surgery at the University of Washington. "Can you say you are comfortable with nearly one in 10 having bad outcomes?"

SCOAP's partner CERTAIN—a program that monitors the risks, benefits and value of new health care treatments and technology to determine whether they improve quality of care and patients' health—also is a Strong for Surgery partner.

Pilot of nutrition checklist

Since May 2012, colorectal surgeons at five Washington hospitals have piloted Strong for Surgery's nutrition checklist. Nutritional status is a major determinant of outcome for high-risk surgical patients and it is the most important independent predictor of outcome in any type of surgery, Dr. Varghese said.

Physicians and their staff members determine, among other things, whether the patient has a BMI lower than 19, or if he or she has unintentionally lost more than eight pounds in the past three months. If the patient is having inpatient surgery, the checklist prompts health professionals to test albumin levels because studies have shown patients with a level between 2.5 and 2.9 g/dL have a 25% higher post-op complication rate. Those with levels between 2.0 and 2.4 g/dL have a 50% higher post-op complication rate.

If the questions and tests reveal that patients don't have proper nutrition, physicians can refer them to a registered dietitian and also can have them take a nutritional supplement in the days leading up to the surgery.

"The checklist isn't a passive tool; it is an instrument," Dr. Varghese said. "It is a great communication tool. It standardizes a process. It provides education tools."

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Optimizing health before surgery

Below are the four areas Strong for Surgery is targeting before patients are on the operating table.

Nutrition

Nutritional status is a major determinant of outcome for the high-risk surgical patient and is the single most important predictor of outcome in any type of surgery. Assessing a patient for unintentional weight loss, change in dietary intake and gastrointestinal symptoms can indicate that a patient may be at nutritional risk. Surgery patients suffer from immune suppression, which increases infection rates.

Glycemic control

Good blood glucose control for diabetic patients reduces the risk of surgical site infections and promotes healing. Having control of blood glucose before surgery lowers the risk of hyperglycemia and hypoglycemia during and after the operation or procedure. Screening all patients is important because as many as one-third have diabetes, but do not know it.

Medication use

A thorough review of all medications, over-the-counter drugs, supplements and herbal remedies is important so the physician can advise the patient on which medicines to continue and which they should stop before surgery.

Smoking cessation

Studies have shown smoking increases pulmonary complication rates after anesthesia by as much as six times. Smoking has been shown to be an independent risk factor for complications including decreased lung function, impaired wound healing and cardiovascular events such as a heart attack.

For more information, visit `www.becertain.org/strong_for_surgery`.

who "may not be able to practice his or her profession with reasonable skill and safety due to a mental or physical condition" (WAC 246.16.235). A report to MQAC or BOMS often generates a public investigation and can result in disciplinary action against the provider.

Alternatively, a report to WPHP almost always can and will remain confidential (WAC 246.16.210). Subsequently, most license holders concerned about the well-being of a colleague greatly prefer to fulfill their reporting obligation by contacting WPHP. The three situations in which a physician's or physician assistant's WPHP participation cannot remain confidential are when there has been clear patient harm in the context of physician impairment, commission of sexual misconduct, or the individual of concern will not comply with WPHP's recommendations for intensive evaluation, treatment and emergent medical leave.

Concerned employers common source of referrals to WPHP

In 2012, 185 new cases were referred to WPHP. Of these, 39% were referred by a concerned employer, 8% were self-referrals, 8% came from a colleague or peer and the rest from a variety of sources. Despite the legal obligations outlined in WAC 246.16.235, anecdotally, most employers and concerned colleagues note they would not intervene in these situations by calling MQAC if a confidential and therapeutic alternative like WPHP ceased to exist.

In West Virginia, Alabama, Mississippi and Georgia, states that have only in recent years established confidential intervention programs such as WPHP, there have been huge upticks in the numbers of providers being treated and monitored for substance abuse or other impairing illnesses.

Our experience in Washington and experience in other states consistently demonstrate that the absence of a confidential and therapeutic program such as WPHP is a significant barrier to early identification and intervention of physician impairment. I urge all physicians to continue to support confidential programs because without confidentiality, safe medical care for the patients of our state would be at risk. ●

REFERENCES

1. Hughes PH, Brandenburg N, Baldwin DC, Storr CL, Williams KM, Anthony JC, Sheehan, DV. Prevalence of Substance Abuse Among US Physicians. JAMA. Vol 267 (No 17); 2333-2339. May 6, 1992.

2. Oreskovich MR, Kaups KA, Balch CM, Hanks JB, Satele D, Sloan J, Meredith CM, Buhl A, Dyrbye LN, Shanafelt TD. The Prevalence of Substance Use Disorders Among American Surgeons. Archives of Surgery. Vol 147 (No 2); 168-174. Feb 2012.

Colorectal surgeon Alessandro Fichera, MD, a professor in the department of surgery at the University of Washington Medical Center and one of the physicians in the pilot program, said having the checklist has helped his practice discover patients they otherwise would not have flagged for needing a nutritional supplement before surgery.

"Before the checklist if someone looked emaciated or had weight loss, it was something we would ask about. Now we ask everybody," he said. "You would be surprised at how many patients it affects. Young. Old. Healthy. Sick."

Dr. Fichera said his patient compliance rate has been higher than 90% when he has prescribed the nutritional supplement.

"It's been very well accepted," he said. "It will be interesting to see the overall complication rates once a large enough group of people are participating in Strong for Surgery. I will be surprised if it doesn't have an impact."

Strong for Surgery has not compiled data yet to compare outcomes before and after implementing the pilot. Similar to Dr. Fichera's experience, though, feedback from other pilot sites has been positive, Dr. Varghese said. Consequently, in the coming year Strong for Surgery will begin rolling out the program to other hospitals.

They also plan to begin incorporating the other three checklist areas dealing with blood glucose, smoking cessation and medication use. And they plan to use the checklists in spinal and vascular surgery, as well as other surgical areas.

Eventually, the program could include checklists for things such as depression and a patient's physical activity, Dr. Varghese said. And the checklists could ultimately incorporate more physicians than just surgeons.

"We've had questions from primary care doctors who want to implement it in their office," Dr. Varghese said. "I have a colleague who says 'everybody is pre-op, you just don't realize it right now.'"

MultiCare, which has hospitals and clinics in Pierce, south King, Thurston and Kitsap counties, is one of the first sites beyond the five pilot programs to begin implementing Strong for Surgery.

MultiCare found a way to place the nutrition checklist into its workflow and Dr. Varghese came in to talk to clinicians in the Tacoma area. In spring 2013, MultiCare began piloting the checklist. About 25 patients were given the nutritional supplement and most took it, said Mark Shellmyer, careline director at MultiCare Health System in Tacoma.

"It is pretty clear that this is the right thing to be doing. A lot of literature supports the fact that patients who are malnourished have a worse outcome," he said. "The whole point of this is that we can prevent problems on the back end if we optimize patients on the front end." ●