Four years ago, the Surgical Care Improvement Project (SCIP) was launched, with the ambitious aim of reducing 3 types of preventable complications by 25% by 2010:

- surgical site infections
- perioperative heart attack
- deep vein thrombosis and pulmonary embolism.

SCIP is a national quality partnership led by 10 organizations and agencies (sidebar, p 8).

With the fifth anniversary a year away, what impact is SCIP making? Is care improving? What’s next for quality reporting? What role will SCIP play in an expanded Medicare pay-for-performance program, if one is approved by Congress?

A way of life

By now, SCIP is a way of life. Hospitals have devoted time and effort to reporting on SCIP and bringing their performance in line with SCIP measures and reporting their data.

SCIP has teeth. For fiscal 2009, 8 SCIP measures are among 30 measures acute care hospitals must report to Medicare to receive their full annual payment update. Hospitals that don’t meet the reporting requirement have their payment update reduced by 2 percentage points. (Requirements differ for critical access hospitals.)

One new SCIP measure is required for fiscal 2010, and 2 more have been proposed for 2011.

An open book

How hospitals are performing on 7 SCIP measures is an open book. Anyone can go to www.hospitalcompare.hhs.gov to see how a hospital is doing on measures such as giving the prophylactic antibiotic at the right time and ordering treatments to prevent venous thromboembolism (VTE).

The financial stick has boosted participation. The number of hospitals submitting their data “doubled overnight” when Medicare began requiring the reporting for a full payment update in 2007, says Dale Bratzler, DO, MPH, president and CEO of the Oklahoma Foundation for Medical Quality, Oklahoma City, which manages SCIP for the Centers for Medicare and Medicaid Services (CMS). In fiscal 2008, 97% of hospitals reported and received their full update.

Making a difference?

Is SCIP making a difference for patients?

Once public reporting started, performance on SCIP measures improved markedly, Dr Bratzler says. That means more patients are receiving evidence-based care:
In 2001, about 56% of Medicare patients got an antibiotic within 60 minutes of surgery. That rose to 92% for the second quarter of 2008.

In 2005, about 70% of patients had documentation of VTE prophylaxis. That is now close to 90%.

Performance is also better on gly-cemic control for cardiac surgery patients, appropriate hair removal, and normothermia for co-lorectal surgery patients (graphs).

Whether SCIP is leading to better patient outcomes is hard to say.

When the SCIP Steering Committee set the 2010 goal to reduce preventable
infections by 25%, no formal outcome measures were developed because of a lack of funding and other reasons.

But there are fewer deaths among Medicare patients in the first 30 days after surgery, Dr. Bratzler notes, with a decline of about 15% between 2004 and 2007. “I don’t necessarily attribute the reduction to SCIP, though SCIP may have contributed,” Dr. Bratzler told OR Manager. “A lot of things have improved—surgery is less invasive, perioperative care is better, anesthesia care is better.”

Still, he says, “surgical mortality seems to be going down at the same time severity of illness, complex conditions, and ages of patients are going up. So the trend is in the right direction.”

He says SCIP has also caused more hospitals to focus on improving quality, which he considers one of SCIP’s contributions.

**Caveat on ‘perfect care’**

What level of performance is expected on the SCIP measures?

For most of the measures, 90% should be achievable, and the national benchmark is 99%, Dr. Bratzler notes. But the target is not 100%, he stresses.

“While many are striving for ‘perfect care,’ you can only have perfect care if you have perfect measures. And we do not,” he says.

There are times a case will fail a measure for legitimate clinical reasons or unforeseen circumstances (such as a drug shortage).

The fact that the target is not 100% “does not excuse poor performance—indeed target rates for most measures are very high,” he says. “However, there will be legitimate reasons for a case to fail a measure that would make an individual surgeon’s rate less than 100%.”

**Moving on to pay-for-performance?**

What role SCIP and other quality measures might play in an expanded Medicare value-based purchasing or pay-for-performance program is a matter of speculation. Congress must act for such a program to be imple-
mented. With the momentum for health care reform, some observers think that could happen this year.

CMS suggested what form value-based purchasing might take in a 2007 report to Congress. In the report, CMS proposed that a percentage of a hospital’s DRG payments be based on a combination of its performance on quality measures and its consumer satisfaction scores, with a 3-year phase-in period. Whether Congress will follow that path is yet to be seen. 

—Pat Patterson

What is SCIP?

The Surgical Care Improvement Project (SCIP) is a national quality partnership of organizations seeking to improve surgical care by reducing surgical complications. SCIP is guided by a steering committee representing 10 organizations that have pledged their commitment and support:

- Agency for Healthcare Research and Quality
- American College of Surgeons
- American Hospital Association
- American Society of Anesthesiologists
- Association of periOperative Registered Nurses
- Centers for Disease Control and Prevention
- Centers for Medicare and Medicaid Services
- Institute for Healthcare Improvement
- Joint Commission
- Veterans Health Administration.

Why focus on surgical safety?

- 30 million operations are performed annually.
- Patients who have postoperative complications have dramatically longer hospital stays, greater mortality, and higher costs:
  - Average length of stay is 3 to 11 days longer.
  - Odds of dying within 60 days increase by 3.4 fold (Silber).
- Complications from surgical errors are costly and sometimes fatal:
  - About 1 in 10 patients who died within 90 days of surgery did so because of a preventable error; 30% of these deaths occurred after discharge.
  - Excess 90-day expenses range from $646 for technical problems like accidental lacerations, to $7,800 for a blood clot or pulmonary problems, to $28,218 for acute respiratory failure (Encinosa).

Sources: Encinosa W E, Hellinger F J. Health Serv Res. 2008;43: 2067-2085.
**SCIP resources**

**CMS quality initiatives**  
www.cms.hhs.gov/QualityInitiativesGenInfo/

**Hospital Compare**  
A government website where the public can find and compare hospitals.  
www.hospitalcompare.hhs.gov

**Joint Commission**  
SCIP Core Measure set  
www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/SCIP+Core+Measure+Set.htm

**Quality improvement organizations (QIOs)**  
Each state has a QIO that contracts with Medicare. QIOs provide support and education on SCIP.  
www.cms.hhs.gov/QualityImprovementOrgs/

**Qualitynet**  
SCIP and quality measure headquarters on the Internet.  
www.qualitynet.org/

**Hospital specifications manual**  
Details on reporting SCIP measures are in the Specifications Manual for National Hospital Inpatient Quality Measures.  
www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099

**SCIP literature review**  
www.qualitynet.org/dcs/ContentServer?c=OtherResource&pagename=Medqic%2FOtherResource%2FOtherResourcesTemplate&cid=1219069853290

**SCIP listserv**  
Ask questions and network with peers. Sign up through the QualityNet website.  
www.qualitynet.org/dcs/ContentServer?c=OtherResource&pagename=Medqic%2FOtherResource%2FOtherResourcesTemplate&cid=1182785075079

**SCIP tools and resources**  
Visit SCIP section in QualityNet website.  
www.qualitynet.org/dcs/ContentServer?c=MQParents&pagename=Medqic%2FContent%2FParentShellTemplate&cid=1228694349383&parentId=Category