

The BAUS Nephrectomy Audit Data Reflections From Across the Pond

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Disclosure

None

Objective

Review BAUS data and provide reflection on

Volumes

Complications

Trends

**Utilizing reported national administrative data
and institutional data**

2013 BAUS Nephrectomy Audit Data

**7591 Nephrectomies reported by 3341
consultants from 145 centers**

(including 168 private patients from 48 consultants)

95% of data entered by hand versus imported

24.5% have one or more follow-up

Patients 59% male

Median age 65 (15 – 93)

- **Median cases per consultant = 16 (1 – 118)**
- **Median per center = 39 (1 – 295)**

Trends in Partial and Radical Nephrectomy: An Analysis of Case Logs from Certifying Urologists

Stephen A. Poon,* Jonathan L. Silberstein, Ling Y. Chen, Behfar Ehdaie, Philip H. Kim and Paul Russo†

From the Urology Service, Department of Surgery and Department of Epidemiology and Biostatistics (LYC), Memorial Sloan-Kettering Cancer Center, New York, New York

THE JOURNAL OF UROLOGY®

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ABU cert/recertification logs from 2002 – 2010

1 year of logs represent ~10% of ABU

3852 non-pediatric urologists submitted logs

82% general urologists

63% private practice only

48384 RN and PN cases

Did not include NU, simple Nx

Median (IQR) number of cases: 8/year (4-16)

25% did fewer than 4 cases/year

ABU has ~11,400 certified urologists with ~1300 listed as retired*

***Personal communication from S. Nakada**



Hospital Volume is a Determinant of Postoperative Complications, Blood Transfusion and Length of Stay After Radical or Partial Nephrectomy

Maxine Sun,^{*,†} Marco Bianchi,[†] Quoc-Dien Trinh, Firas Abdollah, Jan Schmitges, Claudio Jeldres, Shahrokh F. Shariat, Markus Graefen, Francesco Montorsi, Paul Perrotte and Pierre I. Karakiewicz[‡] THE JOURNAL OF UROLOGY[®] Vol. 187, 405-410, February 2012

Identified 48,172 patients with non-metastatic RCC treated with nephrectomy 1998-2007 from Nationwide Inpatient Sample

Stratified into groups based on volume of center

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56% of cases done at a teaching institution

Hospital volume categorization:

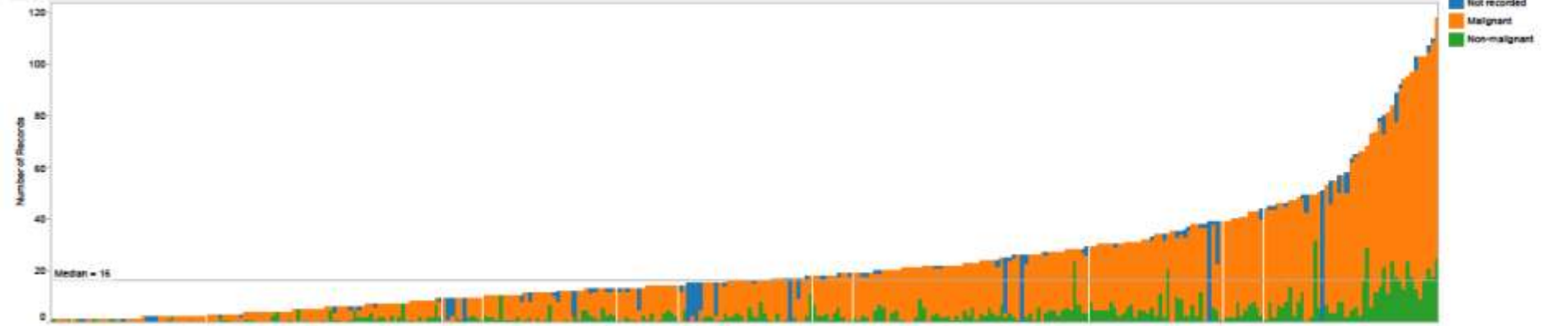
Low	1 – 5	1/3 of cases
Intermediate	6 – 15	1/3 of cases
High	16 or more	1/3 of cases

Only 1.3% of cases done at a center that does more than 100/year



BAUS 2013 data

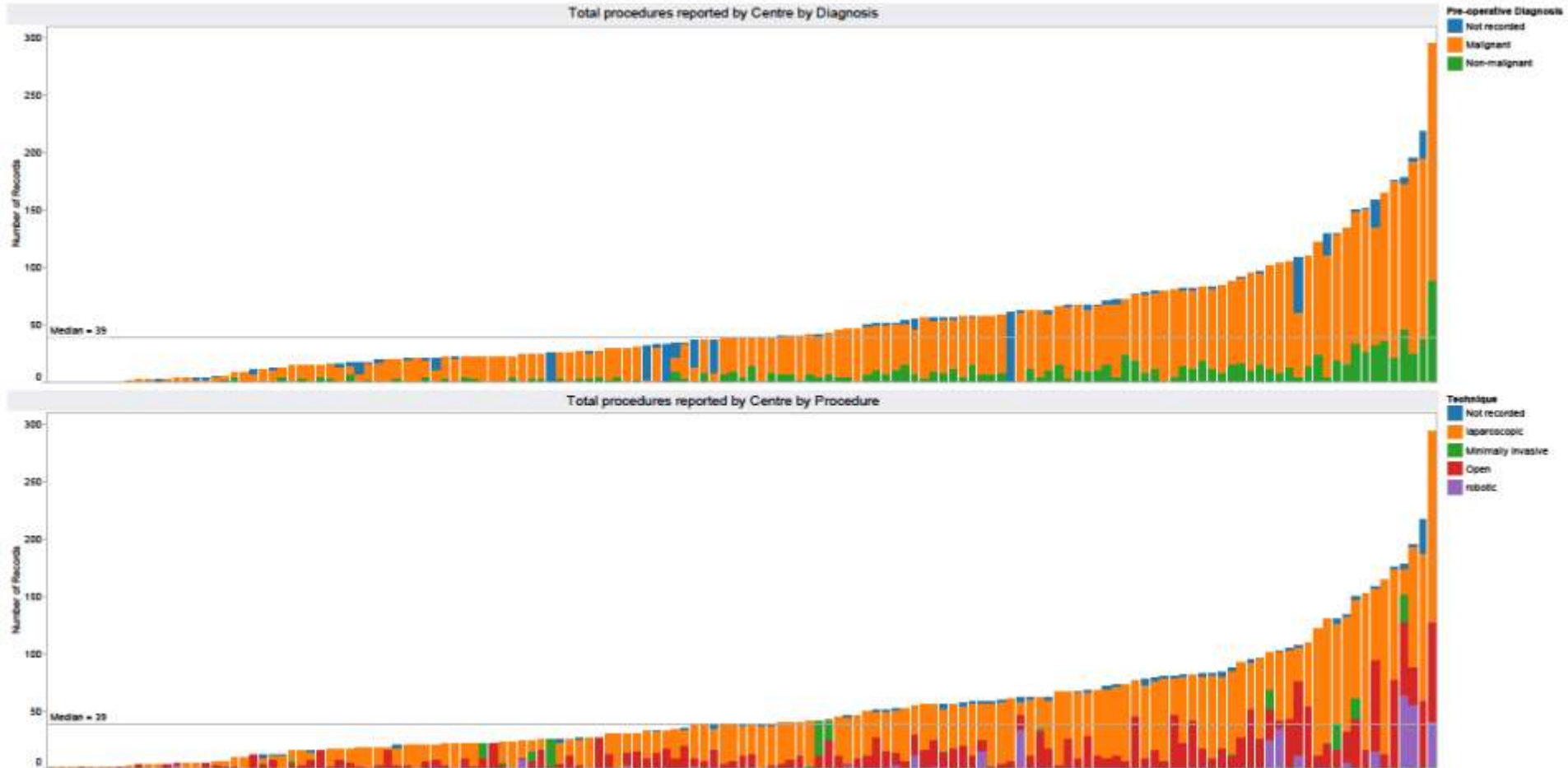
Total procedures reported by Consultant by Diagnosis



Total procedures reported by Consultant by Procedure



BAUS 2013 data



BAUS vs North America

	Case Loads	
	<u>Surgeon</u>	<u>Center</u>
BAUS 2012	14	35
BAUS 2013	16	39*
North America	8	~10

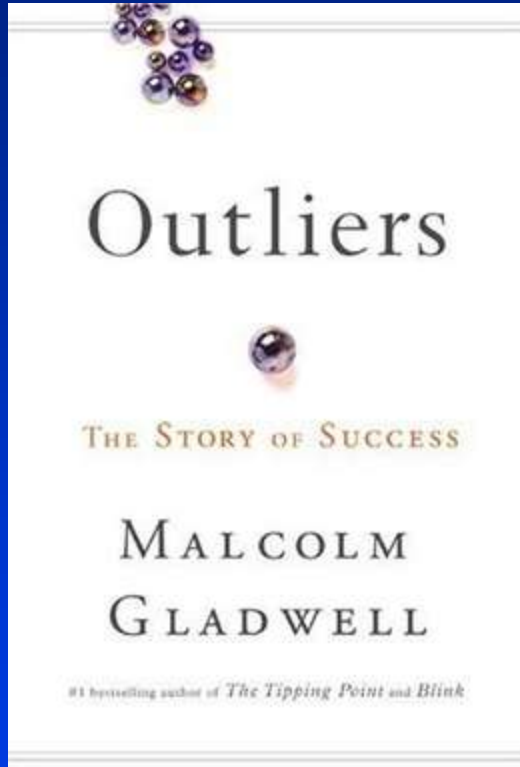
“It is hoped that this is the result of increasing subspecialisation”

Does volume translate to better care?

Practice makes perfect?



Practice makes perfect?



10,000 hours
Based on Ericsson
et al, 1993
Swedish
psychologists
asked musicians
to estimate
amount of time
in practice

Deliberate Practice and Performance in Music, Games, Sports, Education, and Professions: A Meta-Analysis

Psychological Science
2014, Vol. 25(8) 1608–1618
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DOI: 10.1177/0956797614535810
pss.sagepub.com
SAGE



Brooke N. Macnamara¹, David Z. Hambrick², and
Frederick L. Oswald³

¹Princeton University; ²Michigan State University; and ³Rice University

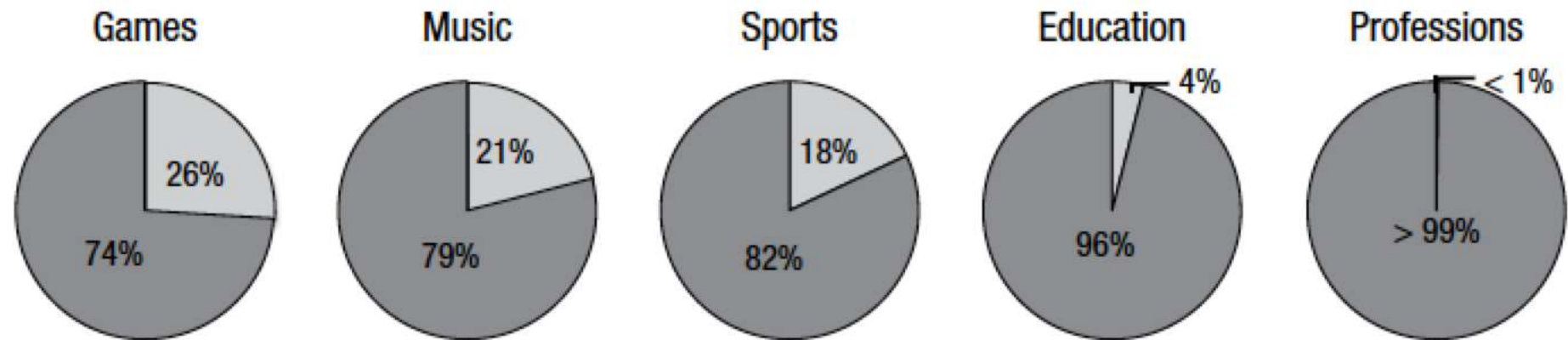


Fig. 3. Percentage of variance in performance explained (light gray) and not explained (dark gray) by deliberate practice within each domain studied. Percentage of variance explained is equal to $r^2 \times 100$.

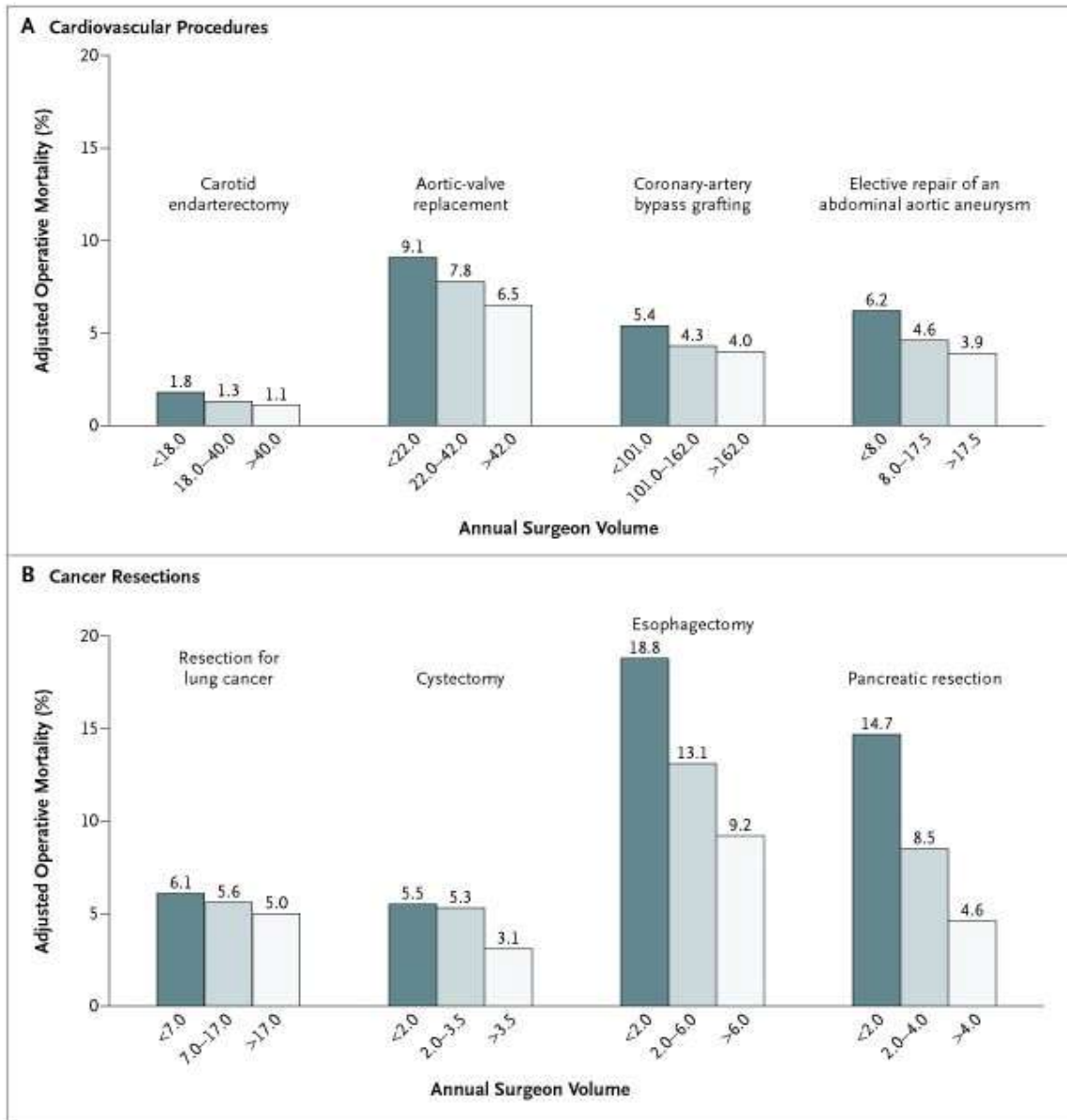
SPECIAL ARTICLE

Surgeon Volume and Operative Mortality in the United States

John D. Birkmeyer, M.D., Therese A. Stukel, Ph.D., Andrea E. Siewers, M.P.H.,
Philip P. Goodney, M.D., David E. Wennberg, M.D., M.P.H.,
and F. Lee Lucas, Ph.D.

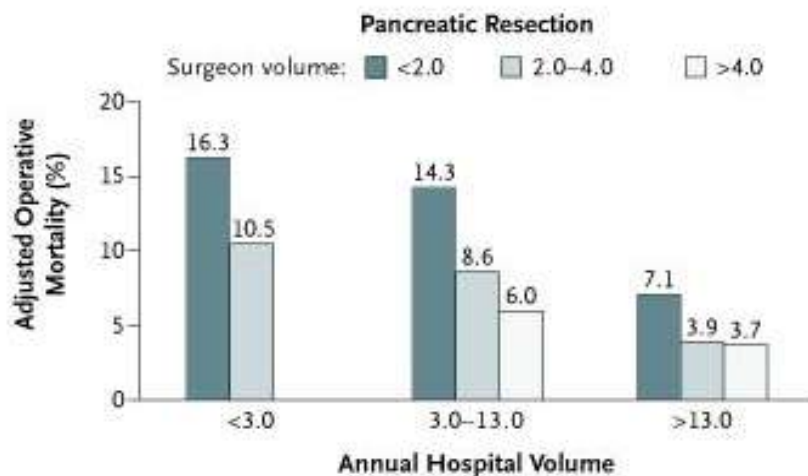
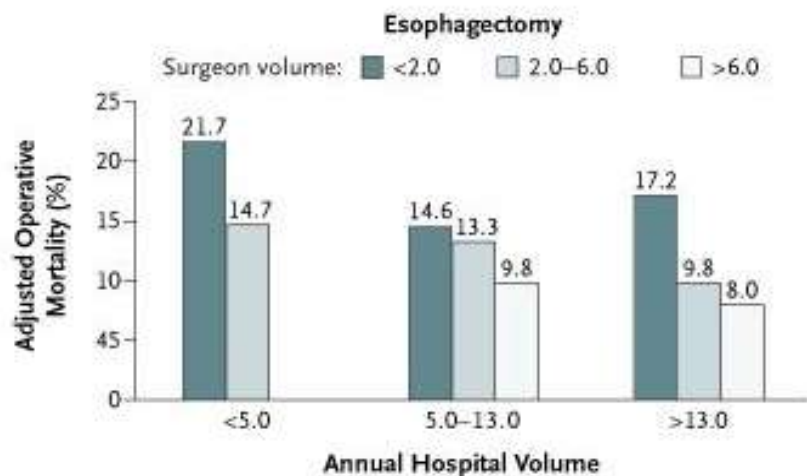
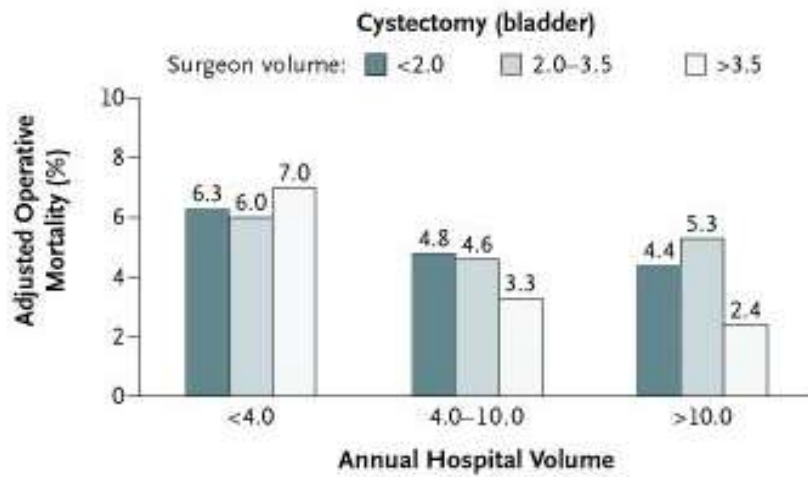
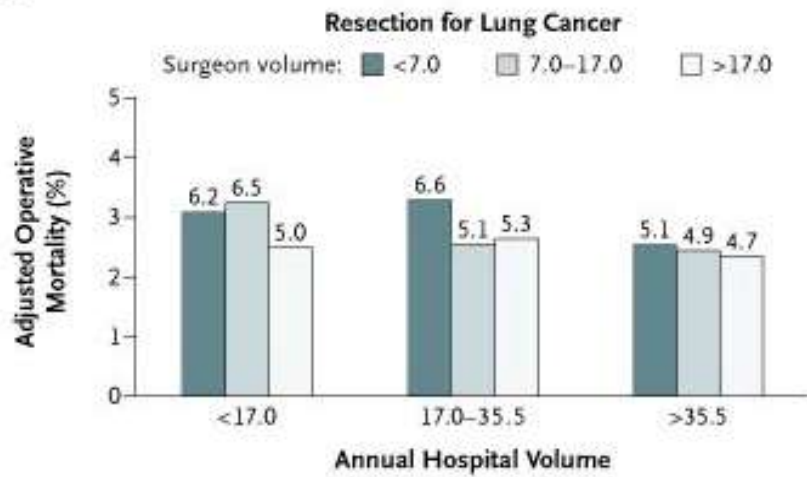
**Medicare claims data 474,108 patients
Examined mortality stratified by surgeon and
hospital volume**

Adjusted Operative Mortality among Medicare Patients According to Surgeon-Volume Stratum



Adjusted Operative Mortality among Medicare Patients According to Hospital-Volume Stratum and Surgeon-Volume Stratum

B



SPECIAL ARTICLE

Surgeon Volume and Operative Mortality in the United States

Table 2. Adjusted Odds Ratio for Operative Death, According to Surgeon Volume and Hospital Volume.*

Procedure	Odds of Operative Death with Low Volume as Compared with High Volume					
	Surgeon Volume		Proportion of Effect of Surgeon Volume Attributable to Hospital Volume %	Hospital Volume		Proportion of Effect of Hospital Volume Attributable to Surgeon Volume %
	<i>adjusted odds ratio (95% CI)</i>			<i>adjusted odds ratio (95% CI)</i>		
Cardiovascular procedures						
Carotid endarterectomy	1.64 (1.47–1.84)	1.70 (1.51–1.91)	0	1.04 (0.92–1.17)	0.89 (0.79–1.01)	—†
Aortic-valve replacement	1.44 (1.29–1.59)	1.45 (1.30–1.63)	0	1.13 (1.00–1.28)	0.97 (0.86–1.10)	100
Coronary-artery bypass grafting	1.36 (1.28–1.45)	1.33 (1.25–1.42)	8	1.26 (1.15–1.37)	1.13 (1.03–1.24)	49
Elective repair of an abdominal aortic aneurysm	1.65 (1.46–1.86)	1.55 (1.36–1.77)	15	1.40 (1.23–1.59)	1.17 (1.02–1.35)	57
Cancer resections						
Resection for lung cancer	1.24 (1.08–1.44)	1.16 (0.99–1.36)	34	1.29 (1.11–1.51)	1.22 (1.04–1.44)	24
Cystectomy of the bladder	1.83 (1.37–2.45)	1.45 (1.03–2.04)	46	2.06 (1.50–2.83)	1.65 (1.14–2.39)	39
Esophagectomy	2.30 (1.54–3.42)	1.80 (1.13–2.87)	38	2.23 (1.47–3.39)	1.67 (1.02–2.73)	46
Pancreatic resection	3.61 (2.44–5.33)	2.31 (1.43–3.72)	50	3.95 (2.55–6.11)	2.34 (1.38–3.99)	54

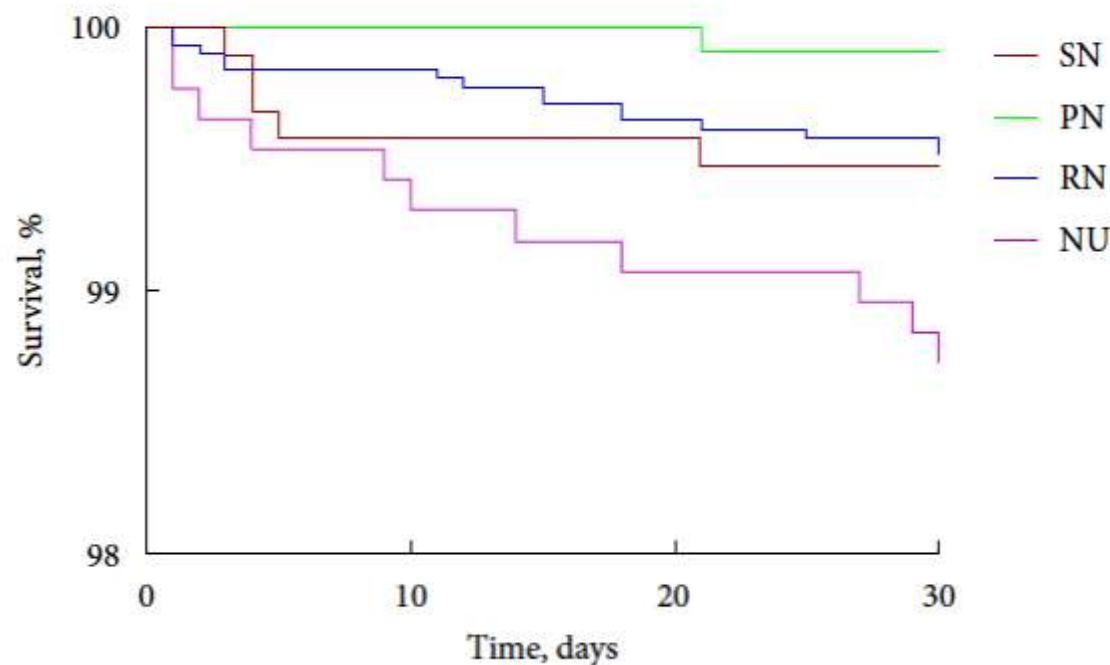
Perioperative outcomes of 6042 nephrectomies in 2012: surgeon-reported results in the UK from the British Association of Urological Surgeons (BAUS) nephrectomy database

John M. Henderson, Sarah Fowler*, Adrian Joyce†, Andrew Dickinson‡ and Francis X. Keeley on behalf of BAUS

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2012 BAUS 30 day survival data

Fig. 1 Kaplan-Meier unadjusted survival curves for nephrectomy type.



Overall 30 day mortality was 0.55%

BAUS mortality data vs US data

Henderson et al BAUS mortality data:

0.1% PN

0.52% RN

Sun et al NIS data, RN + PN:

0.7% in hospital mortality

0.8% low volume, 0.6% “high volume”

BAUS Volume and Mortality data conclusions

**BAUS surgeons are relatively high volume
when compared with colleagues across the
pond**

BAUS surgeons have low mortality rates

**Higher volume and increased specialization
would likely improve metrics further**

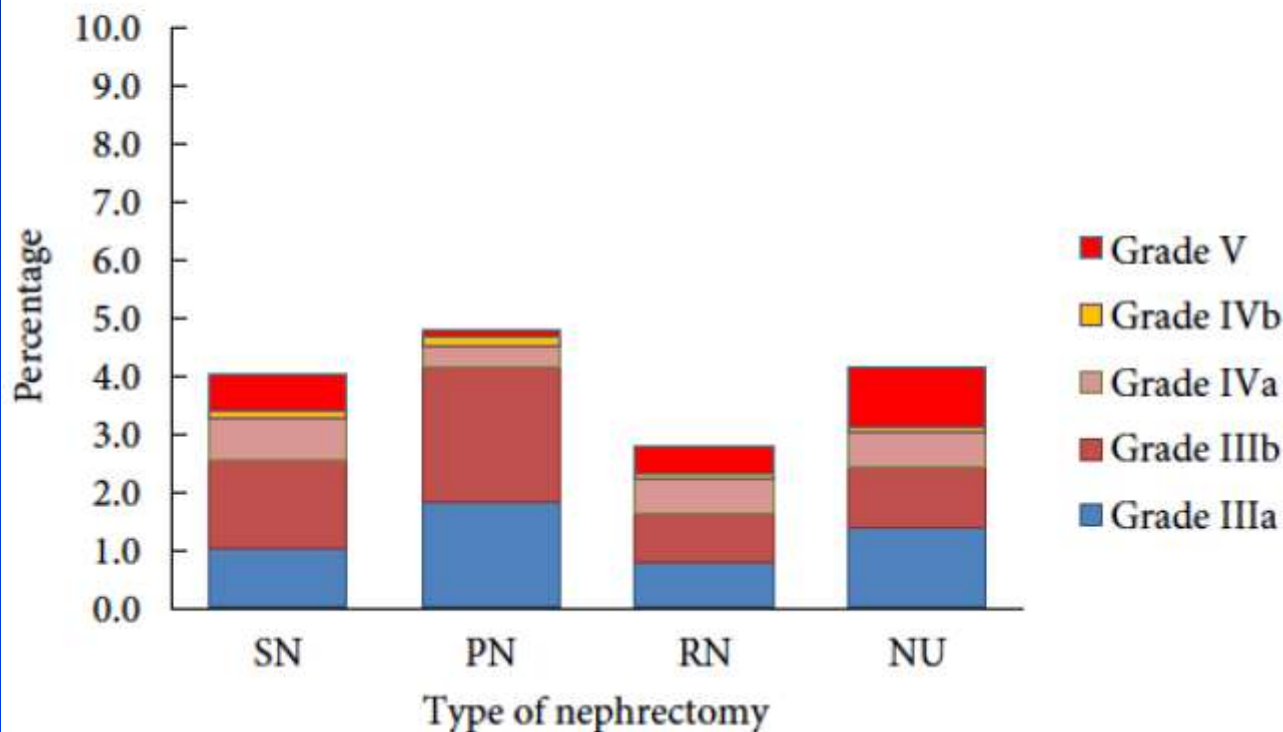


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Fig. 2 The percentage of nephrectomies with Clavien-Dindo complications of grade \geq III.



2013 BAUS complication data

		Clavien Dindo Grade of Complication(s)							
		Technique (group)							
69: Clavien-Dindo grade(s) of comp..	Procedure	Open		Minimally invasive		Not recorded		Grand Total	
		Number of Records	% of Total	Number of Records	% of Total	Number of Records	% of Total	Number of Records	% of Total
Grade I	Radical	57	11.7%	121	16.2%			178	14.3%
	Simple	9	1.9%	31	4.1%			40	3.2%
	Partial	31	6.4%	29	3.9%			60	4.8%
	Nephroureterectomy	9	1.9%	55	7.3%			64	5.1%
	Other			1	0.1%			1	0.1%
	Not recorded	1	0.2%	1	0.1%			2	0.2%
Grade II	Radical	87	17.9%	116	15.5%	3	30.0%	206	16.5%
	Simple	19	3.9%	22	2.9%			41	3.3%
	Partial	54	11.1%	35	4.7%	1	10.0%	90	7.2%
	Nephroureterectomy	16	3.3%	61	8.1%			77	6.2%
	Other	4	0.8%					4	0.3%
Grade IIIa	Radical	16	3.3%	12	1.6%			28	2.2%
	Simple	1	0.2%	8	1.1%			9	0.7%
	Partial	14	2.9%	17	2.3%			31	2.5%
	Nephroureterectomy	8	1.6%	10	1.3%			18	1.4%
Grade IIIb	Other	1	0.2%					1	0.1%
	Radical	8	1.6%	26	3.5%	1	10.0%	35	2.8%
	Simple	2	0.4%	6	0.8%			8	0.6%
	Partial	17	3.5%	19	2.5%			36	2.9%
	Nephroureterectomy	2	0.4%	13	1.7%			15	1.2%
Grade IVa	Other	4	0.8%					4	0.3%
	Radical	15	3.1%	9	1.2%	1	10.0%	25	2.0%
	Simple			5	0.7%			5	0.4%
	Partial	5	1.0%	1	0.1%			6	0.5%
	Nephroureterectomy	2	0.4%	5	0.7%			7	0.6%
Grade IVb	Other	3	0.6%					3	0.2%
	Radical	2	0.4%	3	0.4%			5	0.4%
	Simple			1	0.1%			1	0.1%
	Partial	3	0.6%					3	0.2%
Grade V (death)	Nephroureterectomy			2	0.3%			2	0.2%
	Radical	11	2.3%	8	1.1%	1	10.0%	20	1.6%
	Simple	1	0.2%	2	0.3%			3	0.2%
	Partial	1	0.2%					1	0.1%
	Nephroureterectomy	1	0.2%	3	0.4%			4	0.3%
Not recorded	Other	2	0.4%					2	0.2%
	Radical	40	8.2%	67	8.9%	3	30.0%	110	8.8%
	Simple	1	0.2%	13	1.7%			14	1.1%
	Partial	30	6.2%	21	2.8%			51	4.1%
	Nephroureterectomy	4	0.8%	25	3.3%			29	2.3%
	Other	4	0.8%	1	0.1%			5	0.4%
Not recorded	1	0.2%					1	0.1%	
Grand Total		486	100.0%	749	100.0%	10	100.0%	1,245	100.0%



2013 BAUS data, any complication

PN+RN MIS+open 717 complications

207 not recorded, therefore denominator is
7,384

= 9.7% any complication

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1998 – 2007 NIS data

Any complication

Low volume	17%
Intermediate volume	16%
High volume	14%

The relationship of postoperative complications with in-hospital outcomes and costs after renal surgery for kidney cancer

Simon P. Kim, Bradley C. Leibovich, Nilay D. Shah*, Christopher J. Weight, Bijan J. Borah*, Leona C. Han*, Stephen A. Boorjian and R. Houston Thompson

2012 BJU International | 111, 580-588

**49,983 RCC surgeries at 2037 hospitals
between 2001 – 2008 from NIS**

26% had postoperative complication

**Associated with perioperative mortality and
cost**

COMPLICATIONS OF RADICAL AND PARTIAL NEPHRECTOMY IN A LARGE CONTEMPORARY COHORT

ANDREW J. STEPHENSON,* A. ARI HAKIMI, MARK E. SNYDER AND PAUL RUSSO†

J Urol 2004

1049 RN and PN for cortical renal tumors

180 patients (17%) had at least 1 complication

Grade III – V complications in 32 patients (3%)

	Total No. (%)	No. Complication Grade (%)			
		I	II	III	IV
PN:	33 (9)	13 (4)	9 (2.5)	11 (3)	0
Urinary fistula	20 (5.5)	16	0	4	0
Perinephric abscess	4 (1.1)	0	0	4	0
Acute renal failure	5 (1.3)	0	3	2	0
Retroperitoneal hemorrhage	3 (0.8)	0	2	1	0
Pneumothorax	4 (1.1)	0	4	0	0
Totals	36	16	9	11	0
RN:	21 (3)	7 (1)	8 (1)	3 (0.4)	3 (0.4)
Acute renal failure	3 (0.4)	0	3	0	0
Retroperitoneal hemorrhage	1 (0.1)	0	1	0	0
Adjacent organ injury	7 (1)	4	0	0	3
Bowel obstruction	4 (0.6)	1	0	3	0
Pneumothorax	6 (0.9)	2	4	0	0
Totals	21	7	8	3	3

Complication data summary

	<u>BAUS</u>	<u>NIS</u>	<u>MSKCC</u>
Any	~10%	14-26%	17%
Grade 3-5	4%	???	3%

Many confounders in reporting complications

Surgeon self reporting bias

Referral center patient complexity

Incentives for reporting complications

Disincentives for reporting complications

BAUS surgeons are providing safe care

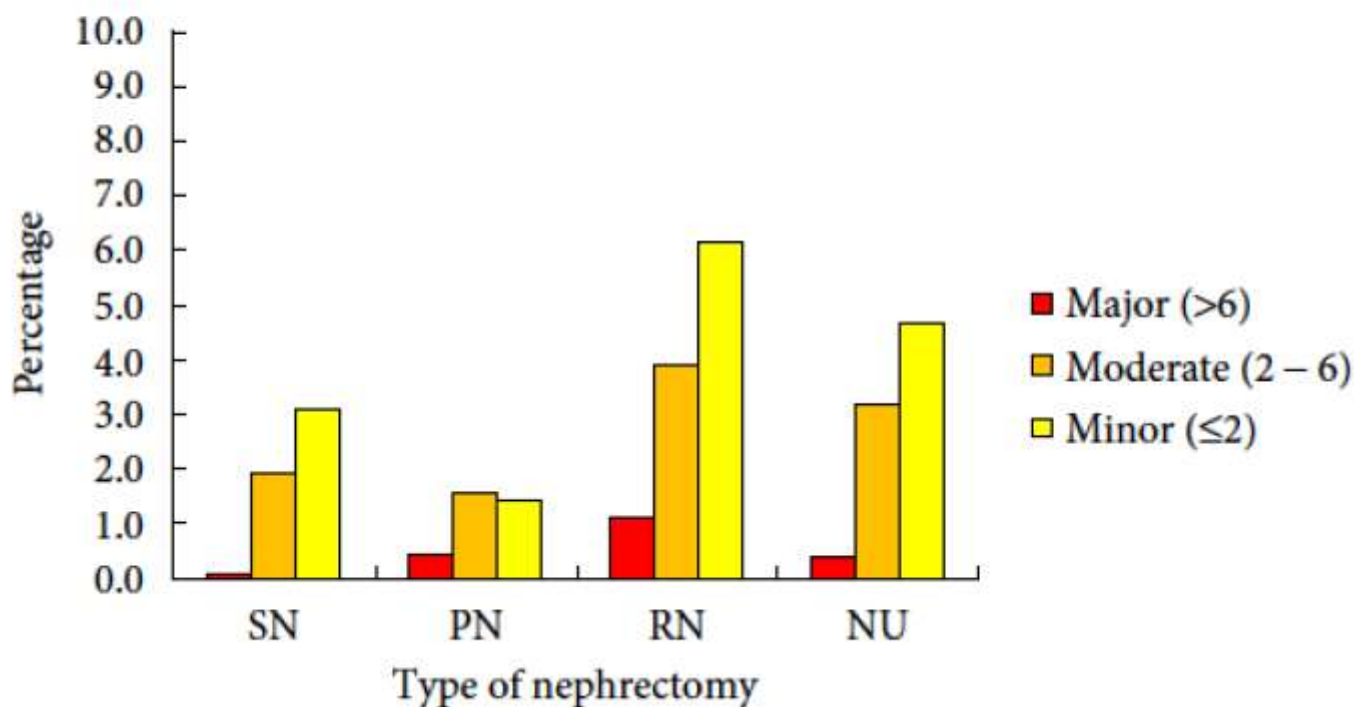


Perioperative outcomes of 6042 nephrectomies in 2012: surgeon-reported results in the UK from the British Association of Urological Surgeons (BAUS) nephrectomy database

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Fig. 3 The Blood transfusion rate during surgical admission for each type of nephrectomy.



BAUS 2013 Transfusion Data

Blood Transfused by Procedure & Technique

84: Number of units of blood transfused related to sur

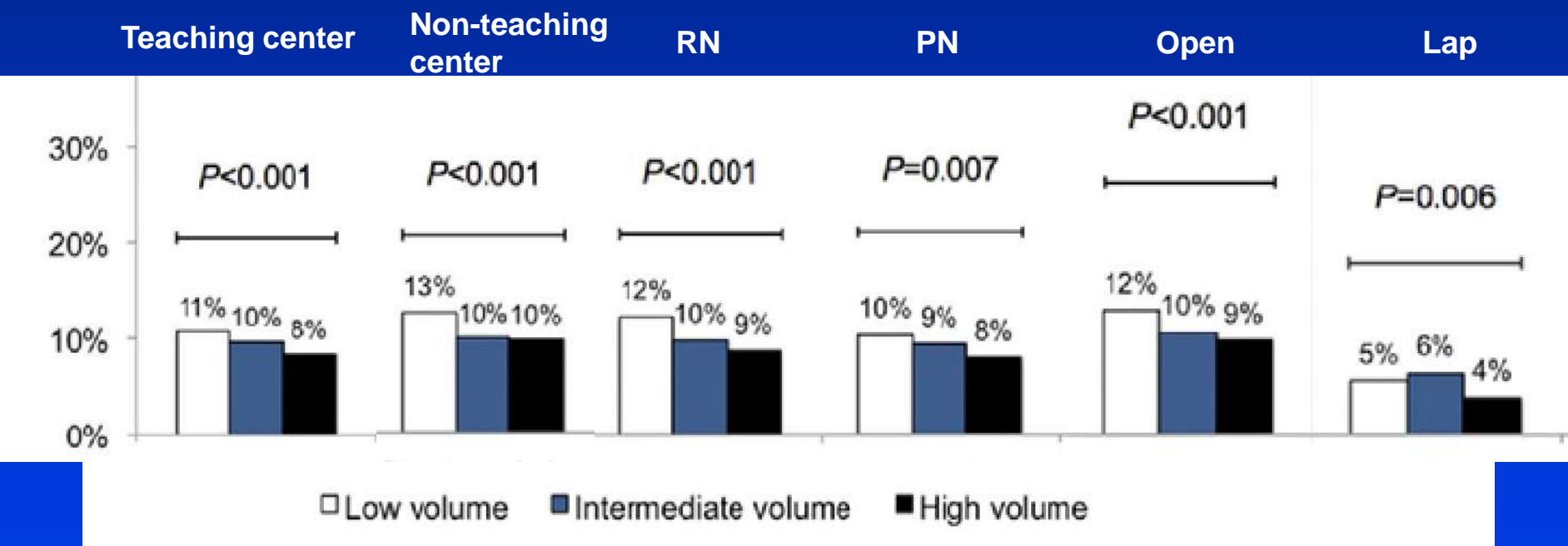
Technique (group)	Procedure	Nil		Minor (<= 2)		Moderate (>2 - 6)		Major (> 6)		Grand Total	
		Number of Records	% of Total Number of Records ..	Number of Records	% of Total Number of Records ..	Number of Records	% of Total Number of Records ..	Number of Records	% of Total Number of Records ..	Number of Records	% of Total Number of Records ..
Open	Radical	597	70.3%	125	14.7%	97	11.4%	30	3.5%	849	100.0%
	Simple	98	83.8%	14	12.0%	3	2.6%	2	1.7%	117	100.0%
	Partial	540	93.8%	28	4.9%	8	1.4%			576	100.0%
	Nephroureterectomy	111	86.0%	15	11.6%	3	2.3%			129	100.0%
	Other	24	43.6%	15	27.3%	10	18.2%	6	10.9%	55	100.0%
	Not recorded	5	100.0%							5	100.0%
Minimally invasive	Radical	2,422	95.7%	74	2.9%	30	1.2%	6	0.2%	2,532	100.0%
	Simple	722	97.7%	11	1.5%	3	0.4%	3	0.4%	739	100.0%
	Partial	644	95.0%	20	2.9%	12	1.8%	2	0.3%	678	100.0%
	Nephroureterectomy	801	94.8%	34	4.0%	7	0.8%	3	0.4%	845	100.0%
	Other	31	96.9%	1	3.1%					32	100.0%
	Not recorded	20	95.2%	1	4.8%					21	100.0%
Not recorded	Radical	20	80.0%	3	12.0%	2	8.0%			25	100.0%
	Simple	2	100.0%							2	100.0%
	Partial	8	100.0%							8	100.0%
	Nephroureterectomy	8	88.9%	1	11.1%					9	100.0%
	Other	5	100.0%							5	100.0%
	Not recorded	1	100.0%							1	100.0%
Grand Total		6,059	91.4%	342	5.2%	175	2.6%	52	0.8%	6,628	100.0%



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Transfusion Data



BAUS Transfusion data vs US data

	<u>2013 BAUS</u>	<u>Sun et al</u>
Open RN + PN	11%	9 – 12%
RN open + lap	9%	9 – 12%
PN open + lap	6%	8 – 10%

The impact of perioperative blood transfusion on survival after nephrectomy for non-metastatic renal cell carcinoma (RCC)

Brian J. Linder, R. Houston Thompson, Bradley C. Leibovich, John C. Cheville*,
Christine M. Lohse†, Dennis A. Gastineau‡ and Stephen A. Boorjian

BJU Int 2014; 114: 368–374

1990 – 2006 Mayo Nephrectomy Registry

2318 cases

825 PN

1493 RN

498 patients (21%) received transfusion

Transfusion associated with

Older

Female

Higher grade

Worse ECOG PS

Symptomatic

Higher stage

Larger tumors

Node positive

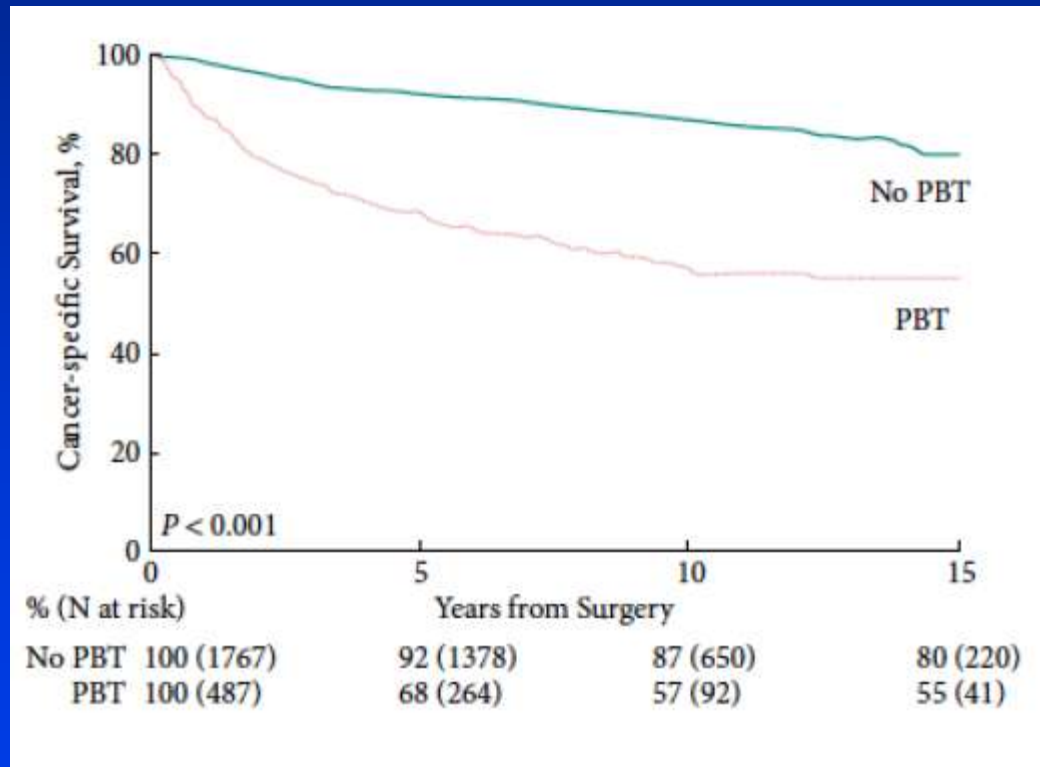
Higher stage



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BJU Int 2014; 114: 368–374



MVA controlling for clinical & pathologic features found transfusion assoc with death from any cause

HR 1.23, $p = 0.02$

BAUS Transfusion data conclusions

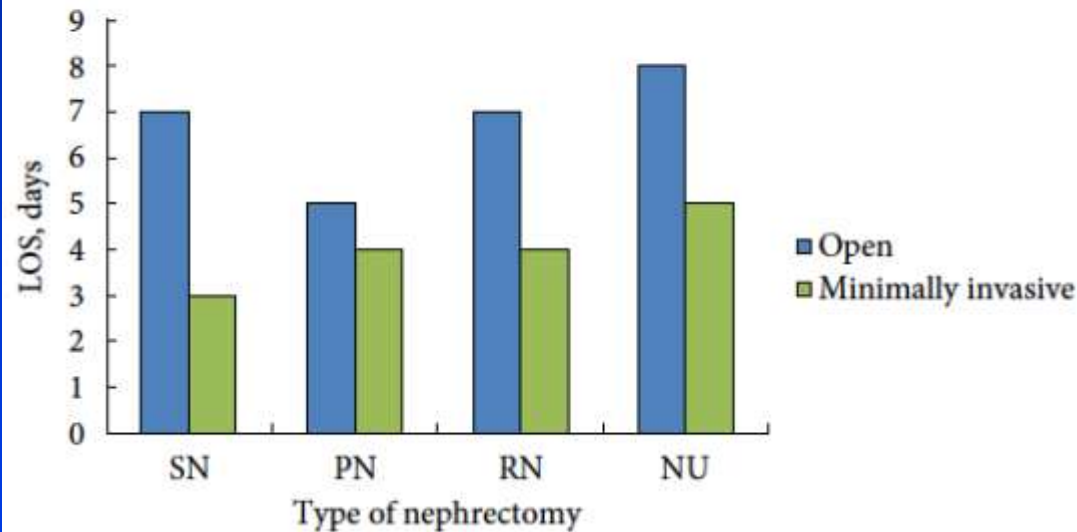
Transfusion rates similar to US and Mayo data

Efforts to reduce transfusion should be undertaken everywhere

LOS

Variability likely related to customs and health system differences

Fig. 4 The median LOS divided by operative technique and type of nephrectomy.



**Mayo mean LOS
2013**

Robot PN	1.3 d
Lap RN/NU	1.7 d
Open PN	3.1 d
Open RN	4.5 d



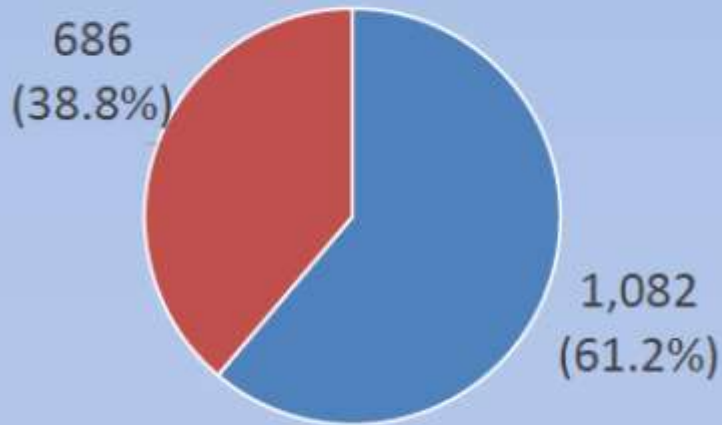
Partial versus Radical Nephrectomy for T1 renal tumours: An analysis from the British Association of Urological Surgeons (BAUS) Nephrectomy Audit

M. Hadjipavlou¹, F. Khan¹, S. Fowler², F.X. Keeley³, S. Sriprasad¹

On behalf of BAUS Sections of Endourology & Oncology

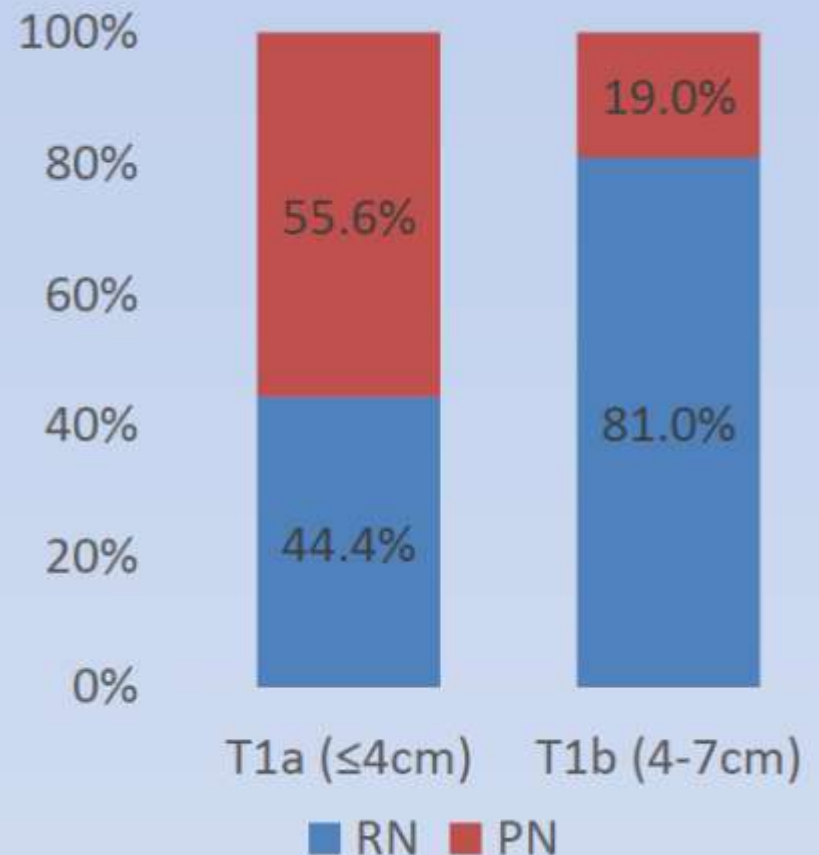
¹Department of Urology, Darent Valley Hospital, Dartford, UK; ²British Association of Urological Surgeons, London, UK; ³Bristol Urological Institute, Southmead Hospital, Bristol, UK

Procedure



■ Radical Nephrectomy (RN)
■ Partial Nephrectomy (PN)

T stage vs Procedure



US NSS Utilization

Miller et al, 2006

SEER review of 14,647 patients with tumor
≤7cm treated surgically

13,246 treated with RN

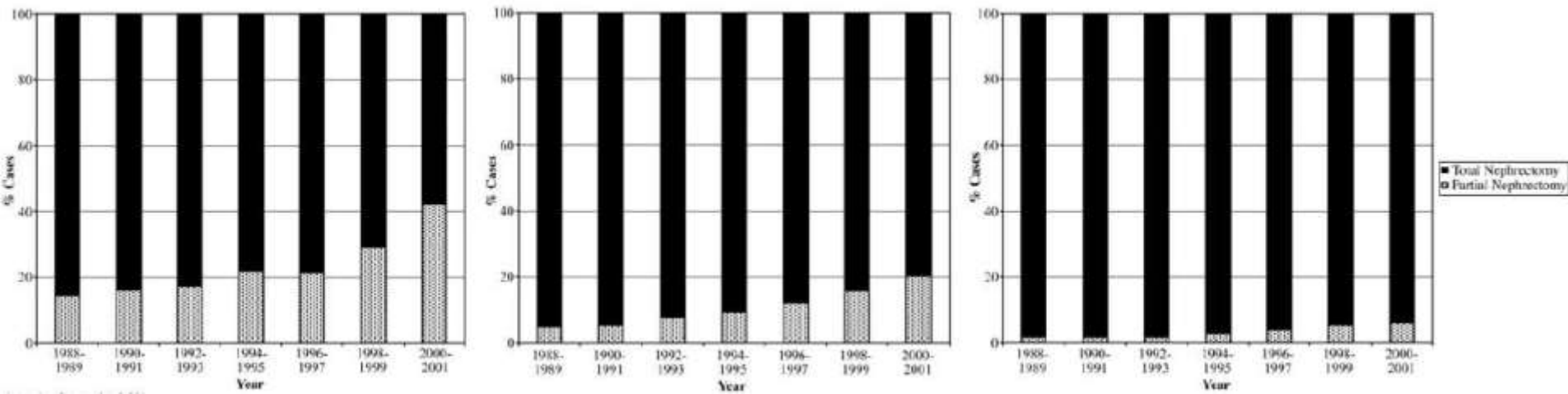
1401 (10%) treated with NSS

Tumor size %NSS 2000-1

<2 cm 42%

2-4 cm 20%

4-7 cm 6%



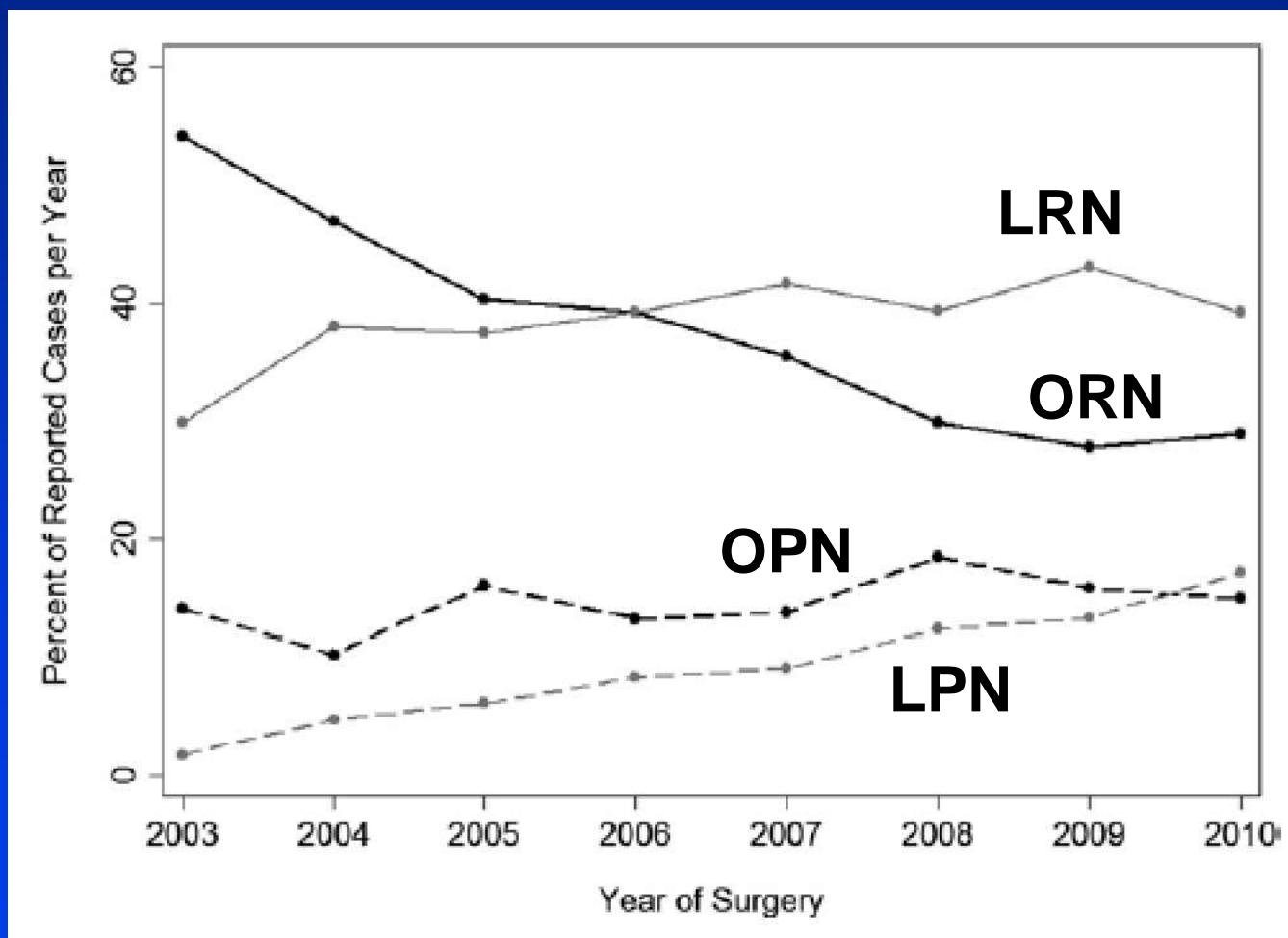
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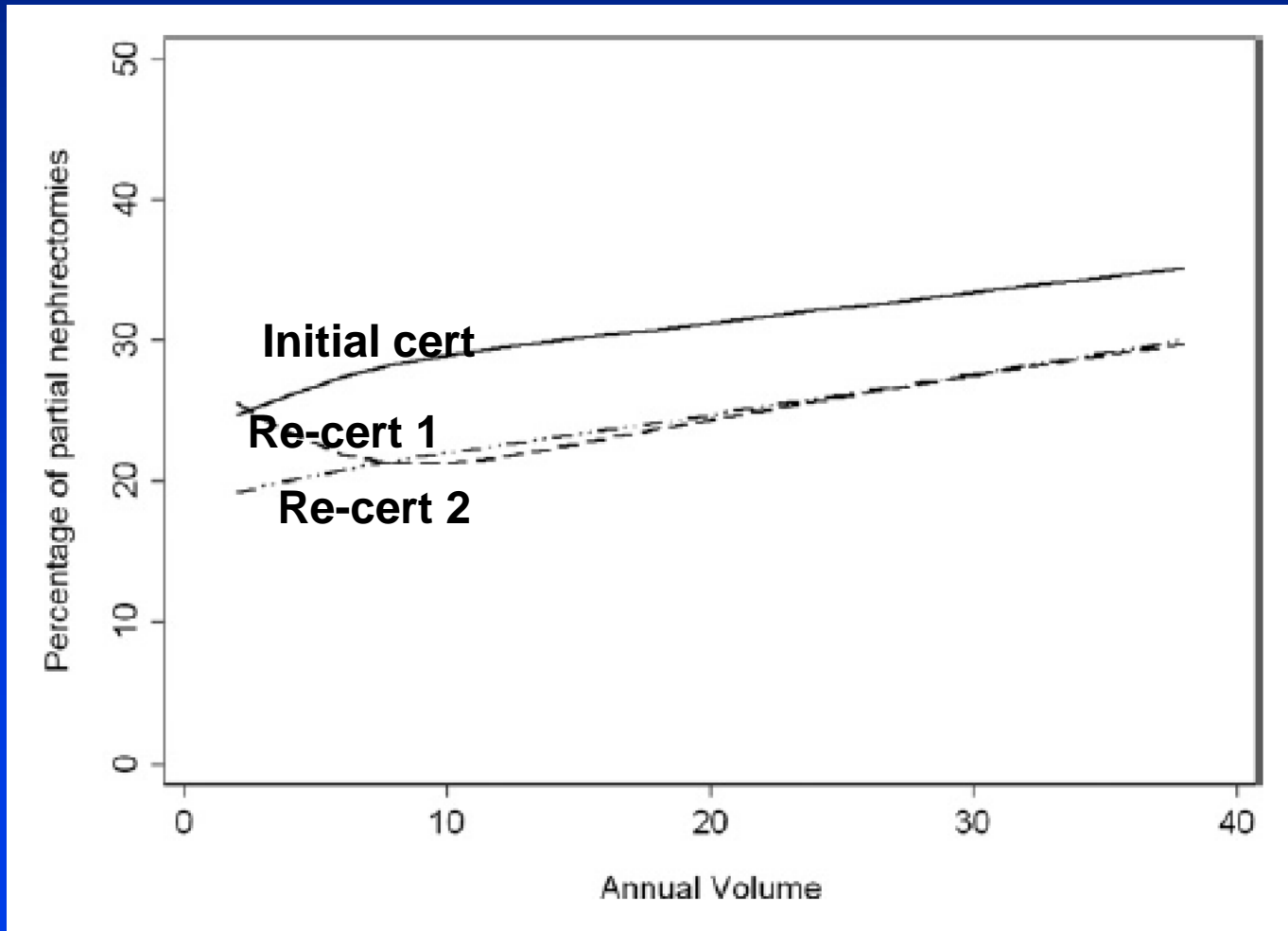
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From the Urology Service, Department of Surgery and Department of Epidemiology and Biostatistics (LYC), Memorial Sloan-Kettering Cancer Center, New York, New York

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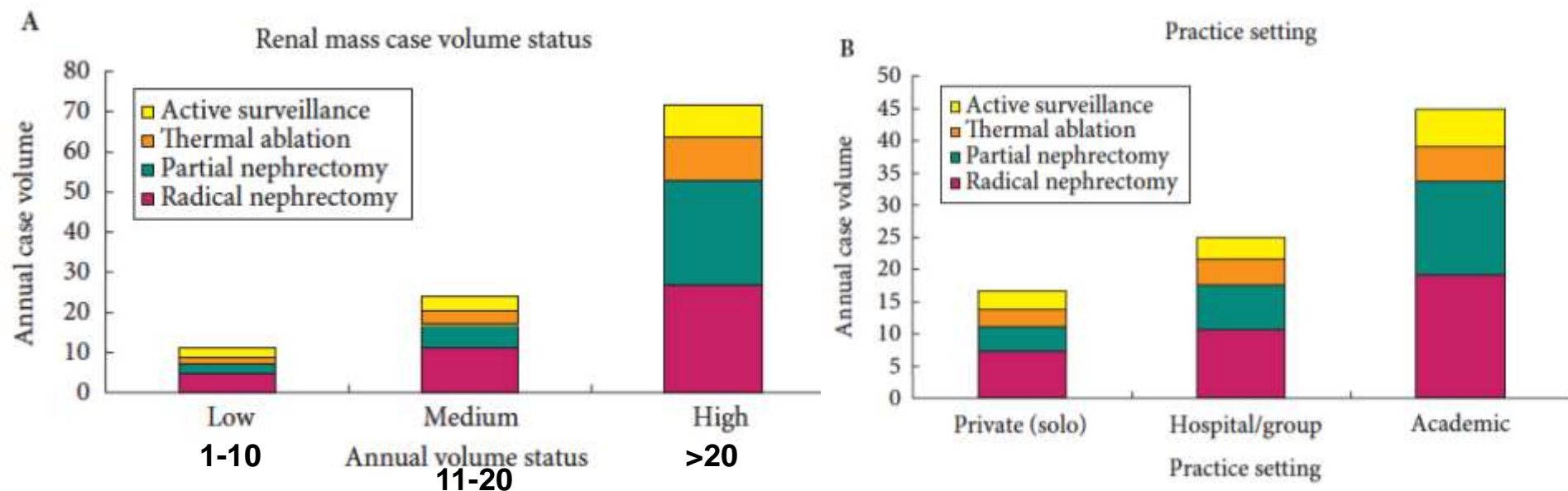
Vol. 190, 464-469, August 2013



Practice-setting and surgeon characteristics heavily influence the decision to perform partial nephrectomy among American Urologic Association surgeons

Christopher J. Weight, Paul L. Crispen*, Rodney H. Breau†, Simon P. Kim, Christine M. Lohse‡, Stephen A. Boorjian, R. Houston Thompson and Bradley C. Leibovich

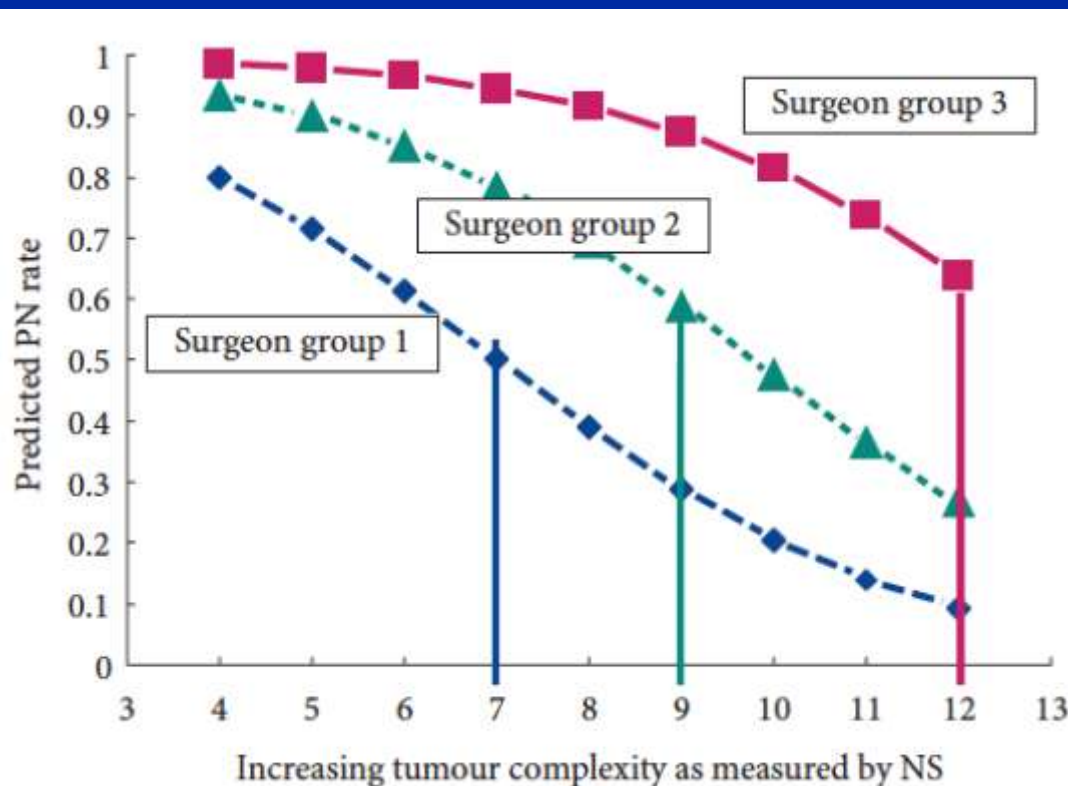
2012 BJU International | 111, 731–738



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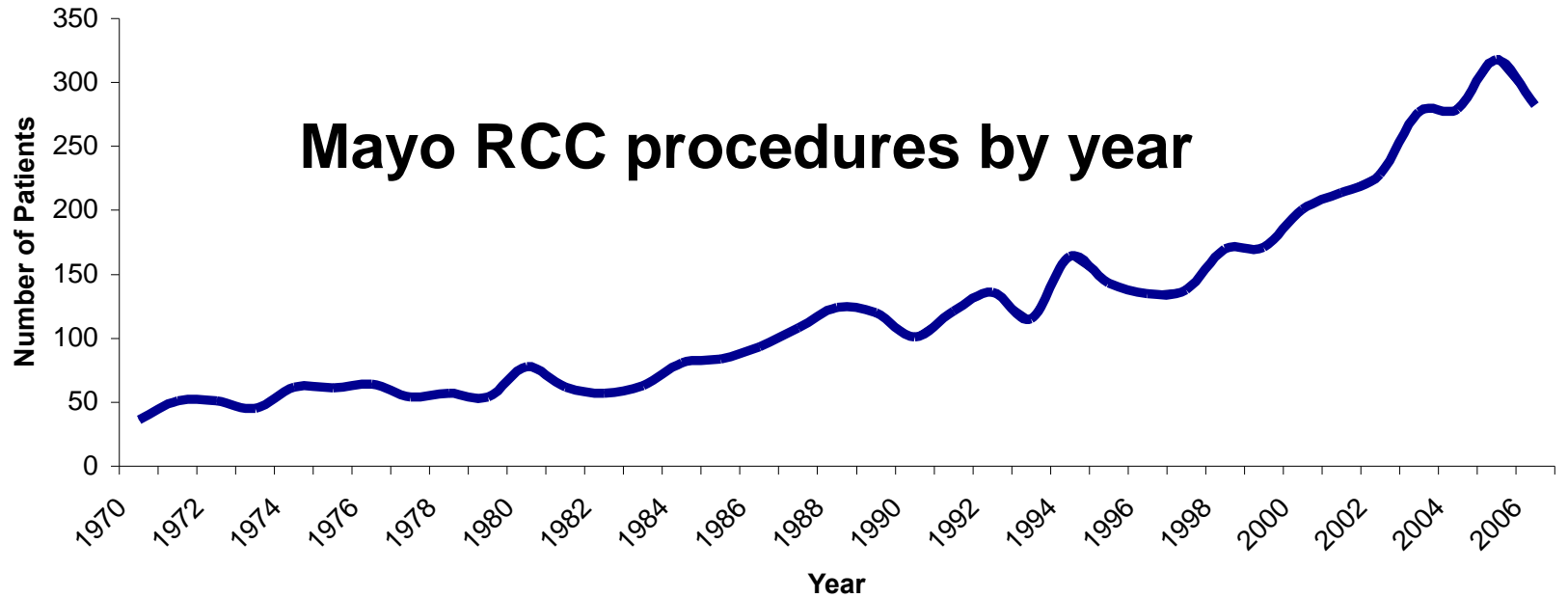


Group 1: Private practice, age of urologist >50, low volume

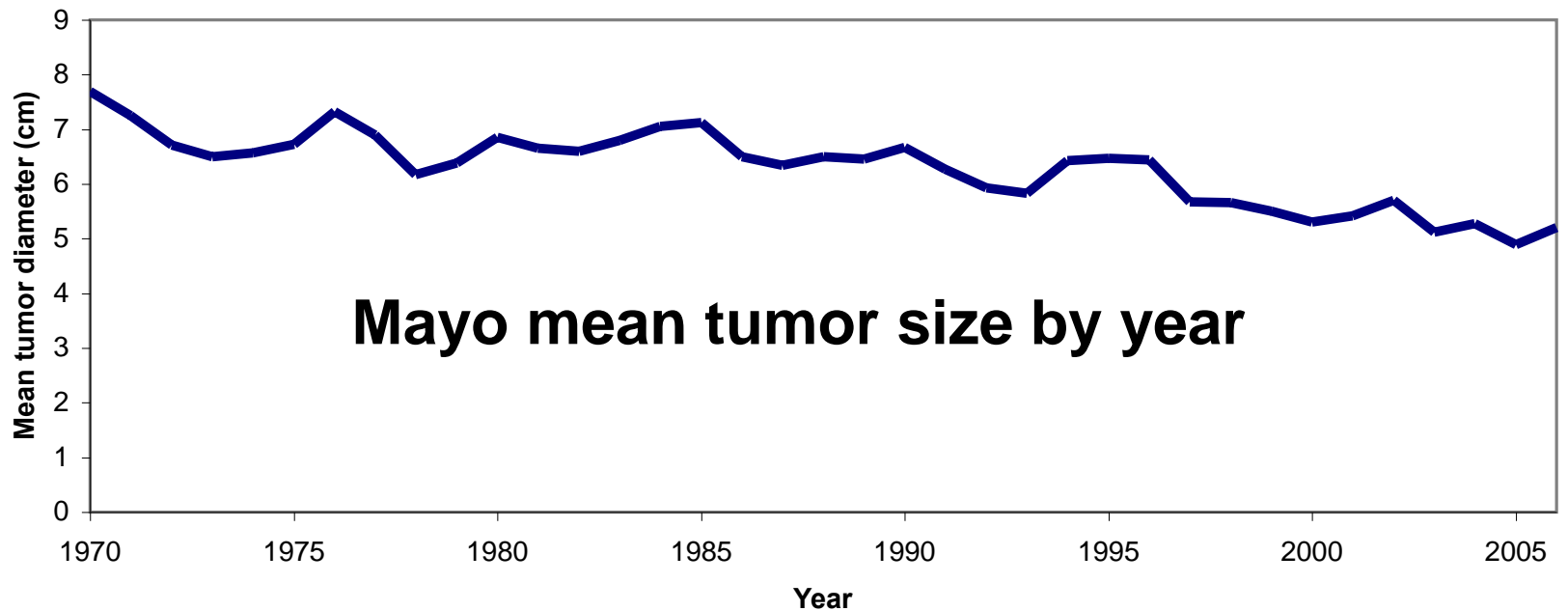
Group 2: Community practice, age 41-50, moderate volume

Group 3: Academic practice, surgeon ≤40, high volume

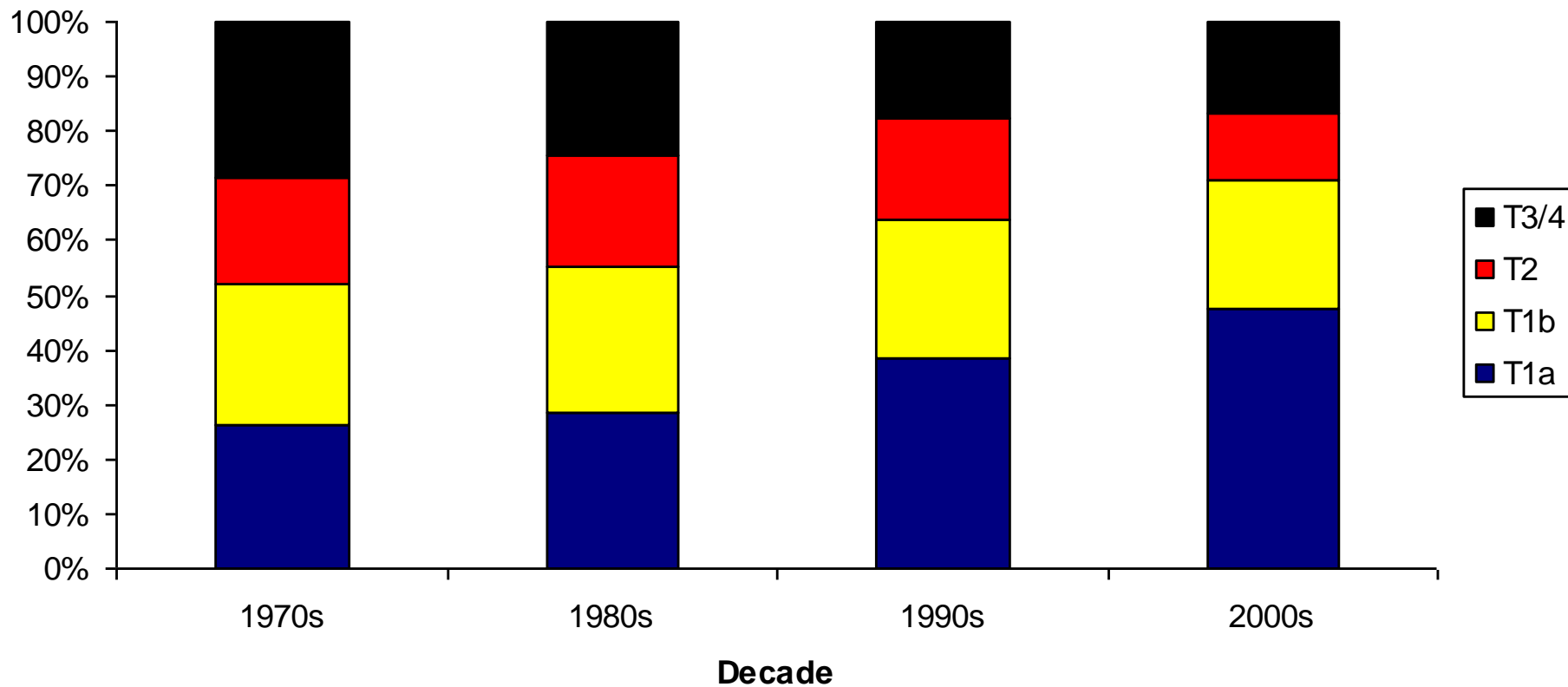
Mayo RCC procedures by year



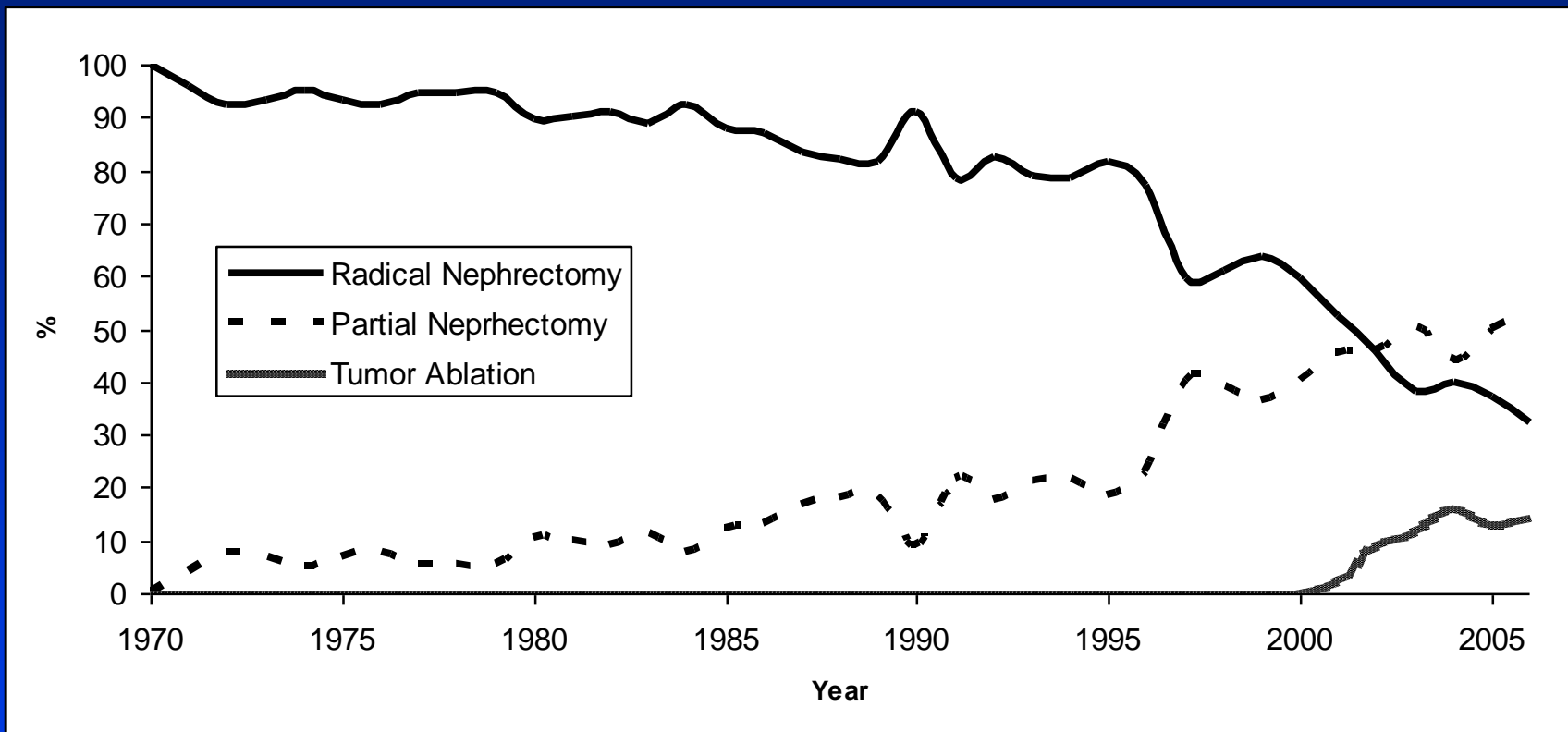
Mayo mean tumor size by year



Mayo RCC primary T stage by decade



Mayo RCC treatment by year



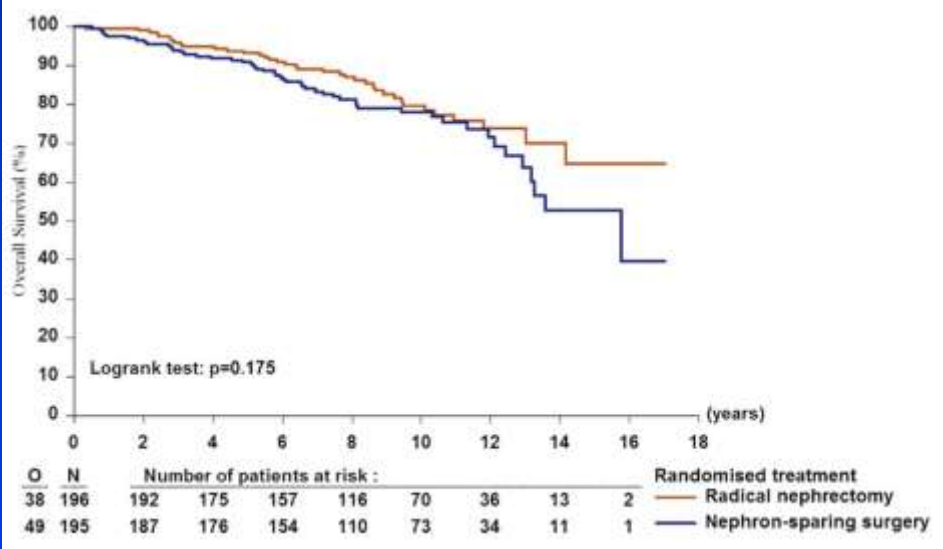
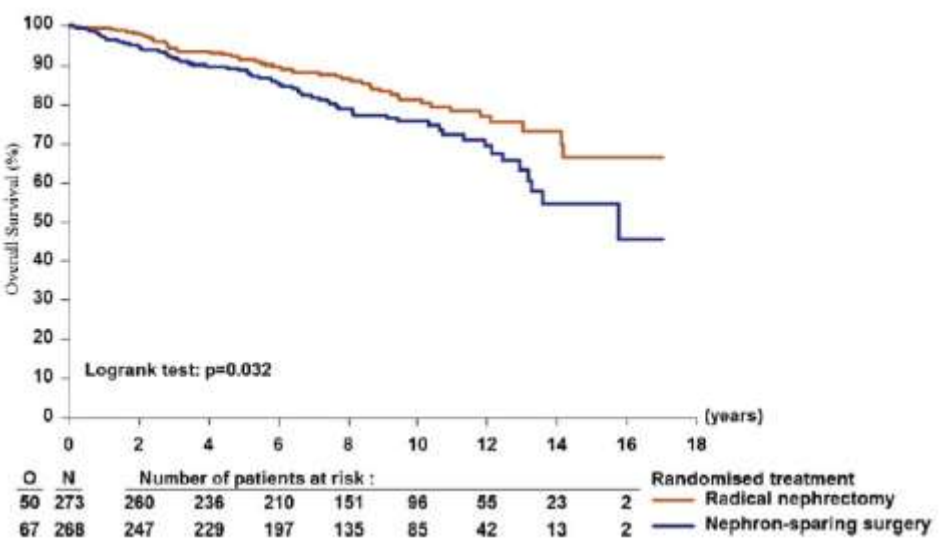
A Prospective, Randomised EORTC Intergroup Phase 3 Study Comparing the Oncologic Outcome of Elective Nephron-Sparing Surgery and Radical Nephrectomy for Low-Stage Renal Cell Carcinoma

Hendrik Van Poppel ^{a,*}, Luigi Da Pozzo ^{b,1}, Walter Albrecht ^c, Vsevolod Matveev ^d, Aldo Bono ^e, Andrzej Borkowski ^f, Marc Colombel ^g, Laurence Klotz ^h, Eila Skinner ⁱ, Thomas Keane ^j, Sandrine Marreaud ^k, Sandra Collette ^k, Richard Sylvester ^k



OS Intent to Treat

OS Eligible Pts w/ RCC





Perioperative Outcomes of Cytoreductive Nephrectomy in the UK in 2012

Jackson BL, Fowler S, Williams ST on behalf of BAUS Section of Oncology, in press BJU

279 Cytoreductive nephrectomies

- 30 day mortality 1.79%
- 52 patients had PS of 2 or more
- 24% received transfusion
 - Associated with number of metastatic sites, tumor size
- 22.6% had a complication
 - Associated with performance status 2 or more
- 40 had preoperative targeted therapy
 - Similar to others in tumor size, T stage, complications
 - Greater number of tumor thrombus

ORIGINAL ARTICLE – UROLOGIC ONCOLOGY

Mortality and Morbidity After Cytoreductive Nephrectomy for Metastatic Renal Cell Carcinoma: A Population-Based Study

Firas Abdollah, MD^{1,2}, Maxine Sun, BSc¹, Rodolphe Thuret, MD^{1,3}, Jan Schmitges, MD^{1,4},
Shahrokh F. Shariat, MD⁵, Paul Perrotte, MD^{1,6}, Francesco Montorsi, MD², and Pierre I. Karakiewicz, MD^{1,6}

17,688 Florida nephrectomies

1063 (6%) were cytoreductive

In hospital mortality 2.4%

Complications 26.5%

Transfusion 24.3%

Each metric associated with:

more advanced age

comorbidities

number of secondary surgical procedures



Pre-surgical Targeted Rx Does Not Increase Peri-operative Complications

N = 44 with median duration of Targeted Rx of 6-7 months

Complication Type	Odds Ratio	<i>p</i>
All complications	0.560	0.145
Re-exploration	1.100	0.993
Re-admission	1.000	0.997
Thromboembolic	1.200	0.990
Cardiovascular	1.115	0.607
Pulmonary	0.765	0.447
Gastrointestinal	1.154	1.000
Infectious	1.009	0.995
Incision related	0.955	0.880



available at www.sciencedirect.com
journal homepage: www.europeanurology.com



European Association of Urology

Platinum Priority – Kidney Cancer

Editorial by Axel Bex and Noel Clarke on pp. 919-920 of this issue

The Impact of Targeted Molecular Therapies on the Level of Renal Cell Carcinoma Vena Caval Tumor Thrombus

Nicholas G. Cost^a, Scott E. Delacroix Jr.^b, Joshua P. Sleeper^a, Paul J. Smith^a, Ramy F. Youssef^a, Brian F. Chapin^b, Jose A. Karam^b, Stephen Culp^b, E. Jason Abel^b, James Brugarolas^c, Ganesh V. Raj^a, Arthur I. Sagalowsky^a, Christopher G. Wood^b, Vitaly Margulis^{a,*}

25 pts with RCC + IVC VTT *in situ* received targeted Rx

Therapy: sunitinib: 12 bevacizumab: 9
 temsirolimus: 3 sorafenib: 1

VTT level: II III IV
 18 5 2

Targeted Therapy and in situ VTT

Cost et al, Eur Urol 2010

Number of cases with change in tumor thrombus

	<u>Level</u>	<u>Diameter</u>
Increased	1	8
Stable	21	2
Decreased	3*	11

*1 each Level IV-III, level III-II, level II-0

Regression limited to sunitinib treated patients



Data reporting USA



American
Urological
Association

ABOUT US EDUCATION RESEARCH ADVOCACY INTERNATIONAL PRACTICE RESOURCES

Guidelines & Policies

Coding and
Reimbursement

Conferences and
Meetings

Practice Managers'
Network

Patient Safety &
Quality of Care

AUA Quality Registry
(AQUA)

Accreditations and
Reporting

Urology Care
Foundation Patient
Education

PRACTICE RESOURCES > [AUA Quality Registry \(AQUA\)](#)



AUA QUALITY REGISTRY (AQUA)

Overview **Timeline** Participation Fact Sheet FAQs

As part of its ongoing commitment to improving the quality of care for patients with urologic disease, the AUA recently announced it is developing the AUA AQUA Registry.

The AQUA Registry will be the only **specialty-wide, urologic disease** focused **registry** in the United States and will be designed to measure and report health care quality and patient outcomes. Through the aggregation and organization of both clinician- and patient-reported data on diagnostic and therapeutic interventions, clinical and patient-reported outcomes and resource utilization, AQUA will provide the urologic community with a definitive resource for informing and advancing urology within the United States.

Starting with prostate cancer, the AQUA Registry will gradually expand to include other urological conditions.

Data reporting USA



ABOUT US

Guidelines

Coding and Reimbursement

Conference Meetings

Practice Management Network

Patient Safety and Quality of Care

AUA Quality (AQUA)

Accreditation Reporting

Urology Care Foundation Education



AMERICAN COLLEGE OF SURGEONS
Inspiring Quality Highest Standards. Better Outcomes.

ACS NSQIP®

Nine of the top 10 *U.S. News and World Report*-ranked hospitals use ACS NSQIP to improve surgical quality.



About ACS NSQIP

Program Specifics

Join Now

Participants

Downloads

About ACS

Newsroom



Welcome to ACS NSQIP

Today's healthcare environment demands more than ever of surgeons and the hospitals they work in. Payors, including Medicare, increasingly refuse to pay for treating complications deemed preventable, such as surgical site infections. A growing movement aims to tie reimbursements to outcomes – and publicly report the results. At the same time, hospitals face staffing shortages and financial pressures, trying to do more with less. Discover what hundreds of hospitals across America already know. A surgical quality improvement program so effective that EACH YEAR a hospital uses it, on average, it has the opportunity to:

- ▶ Prevent 250-500 complications
- ▶ Save 12-36 lives
- ▶ Reduce costs by millions of dollars

Discover the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®). ACS NSQIP is the leading nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care in the private sector. ACS NSQIP has the tools, training, customization options and, most importantly, data, to keep your hospital ahead of the curve.

REDUCING SSI RATES BY INTRODUCING THE CLEAN PROGRAM AT A BRITISH COLUMBIA COLLABORATIVE

Search [SEARCH](#)

WORKSTATION LOG-IN

[Main Registry \(login required\)](#)

SCR TRAINING & TESTING

[SCR Training and Certification Exam Portal \(login required\)](#)

ACS NSQIP VIDEO



[Click to view the video](#)

LATEST ACS NSQIP NEWS

04.2.14 [New Study Shows Florida's Participation in Innovative ACS NSQIP Surgical Collaborative](#)



2014 ACS NSQIP® National Conference

ACS NSQIP® RISK CALCULATOR



Data reporting USA

AMERICAN COLLEGE OF SURGEONS

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ABOUT US

Guidelines
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Conference Meetings
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Patient Safety
Quality of Care
AUA Quality (AQUA)
Accreditation Reporting
Urology Care Foundation Education

2014 National

Improving outcomes for
UROLOGICAL CARE


Michigan Urological Surgery Improvement Collaborative

Program Overview

The overall aims of the collaborative include, among others, evaluating and improving patterns of care in the radiographic staging of men with newly diagnosed prostate cancer, reducing biopsy-related complications and assessing repeat biopsy patterns, improving patient outcomes after radical prostatectomy, enhancing patient-centered decision making among men considering local therapy for early-stage prostate cancer, and understanding and reducing variation in the use of androgen deprivation therapy. Participating practices submit data to a clinical registry maintained by the MUSIC Coordinating Center and tri-annual consortium-wide meetings are held each year to discuss data, review risk-adjusted measures of processes of care and patient outcomes, and identify strategies and best practices for quality improvement. MUSIC is managed by the MUSIC Coordinating Center, which is housed at the University of Michigan, and funding is provided by Blue Cross Blue Shield of Michigan (BCBSM). BCBSM's Value Partnerships program provides clinical and executive support for all CQI programs. To learn more about Value Partnerships, visit www.valuepartnerships.com.

04.2.14 New Study Shows Florida's Participation in Innovative ACS NSQIP Surgical Collaborative

ACNSQIP®
RISK CALCULATOR

REDUCING SSI RATES BY INTRODUCING THE CLEAN PROGRAM AT A BRITISH COLUMBIA COLLABORATIVE



Data reporting USA

The screenshot displays the American College of Surgeons (ACS) website. The header includes the ACS logo, the text "AMERICAN COLLEGE OF SURGEONS", and the tagline "Inspiring Quality: Highest Standards, Better Outcomes". A search bar is located in the top right corner. The main navigation menu includes "Member Services", "Quality Programs", "Education", "Advocacy", "Publications", and "About ACS". The left sidebar contains a list of navigation items: "ABOUT US", "Guidelines", "Coding and Reimburse", "Conference Meetings", "Practice Ma Network", "Patient Saf Quality of", "AUA Quali (AQUA)", "Accrediti Reporting", "Urology Ca Foundator Education", "ACS NSQIP", and "RISK CALC". The main content area shows a breadcrumb trail: "American College of Surgeons > Quality Programs > Quality Cancer Tools > Cancer Program Practice Profile Reports (CP3R)". Below the breadcrumb is a "Back to National Cancer Data Base" link. A "Quality Cancer Tools" menu is visible, listing "Hospital Comparison Benchmark Reports (HCBR)", "NCDB Survival Reports", "Cancer Program Practice Profile Reports (CP3R)", and "Rapid Quality Reporting System (RQRS)". The "Cancer Program Practice Profile Reports (CP3R)" section is highlighted. The text describes the CP3R tool as a web-based platform for local providers to assess adherence to standard of care therapies for major cancers. It states that the tool provides a platform for promoting continuous practice improvement to improve patient care quality at the local level and allows hospitals to compare their care for these patients relative to other providers. The aim is to empower clinicians, administrators, and other staff to work cooperatively and collaboratively to identify problems in practice and delivery and to implement best practices that will diminish disparities in care across Commission on Cancer (CoC)-accredited cancer programs. The "Current CP3R measures:" section lists four bullet points: 1. Radiation therapy is administered within one year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer. 2. Combination chemotherapy is considered or administered within four months (120 days) of diagnosis for women under age 70 with AJCC T1cN0M0 or Stage II or III hormone receptor negative breast cancer. 3. Tamoxifen or third generation aromatase inhibitor is considered or administered within one year (365 days) of diagnosis for women with AJCC T1cN0M0 or Stage II or III hormone receptor positive breast cancer. 4. Radiation therapy is considered or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with ≥ 4 positive regional lymph nodes.

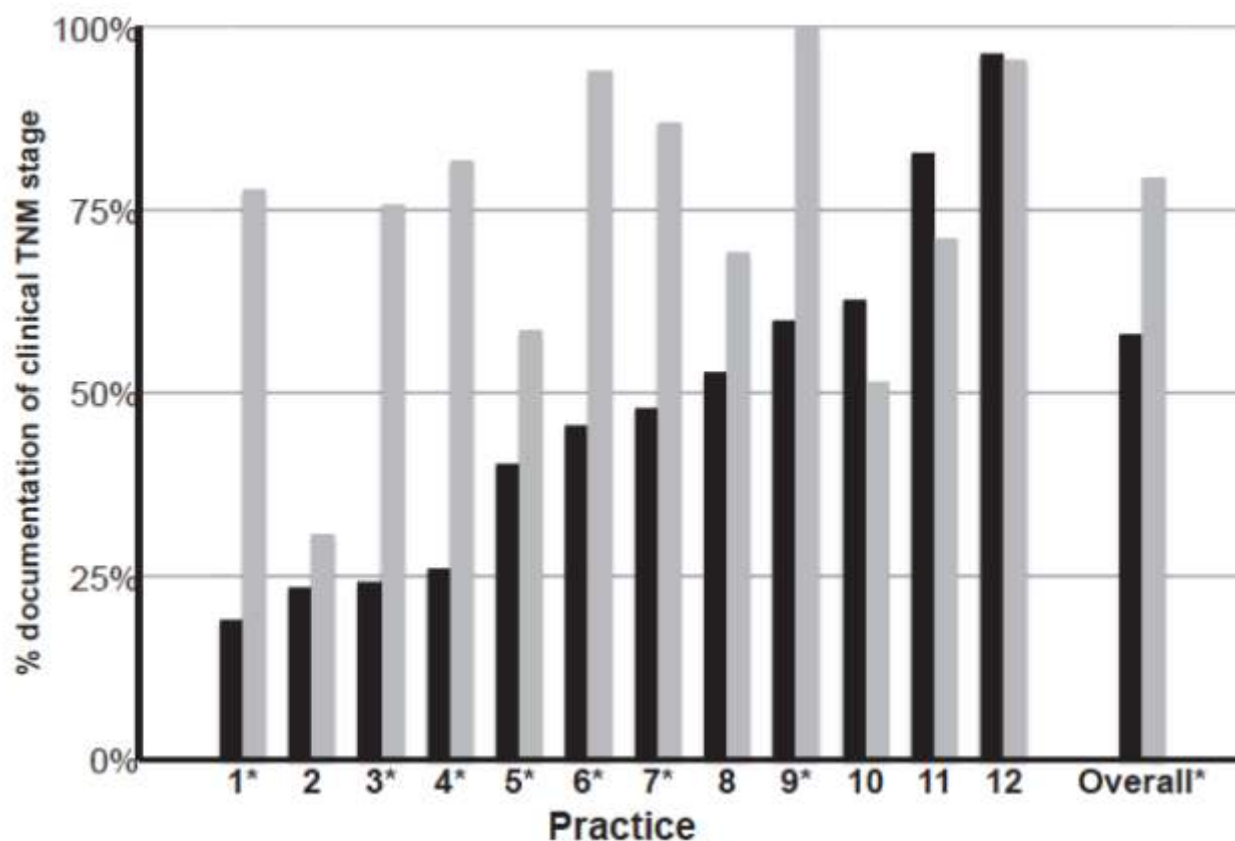


Rank	Hospital	Points*	High-ranking specialties*
1	Mayo Clinic, Rochester, Minnesota	29	15
2	Massachusetts General Hospital, Boston	28	15
3	Johns Hopkins Hospital, Baltimore	26	15
4	Cleveland Clinic	26	14
5	UCLA Medical Center, Los Angeles	23	15
6	New York-Presbyterian University Hospital of Columbia and Cornell, New York	22	12
7	Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia	19	11
8	UCSF Medical Center, San Francisco	17	10
9	Brigham and Women's Hospital, Boston	15	10
10	Northwestern Memorial Hospital, Chicago	13	10
11	University of Washington Medical Center, Seattle	12	9
12 (tie)	Cedars-Sinai Medical Center, Los Angeles	11	8
12 (tie)	UPMC-University of Pittsburgh Medical Center	11	8
14	Duke University Hospital, Durham, North Carolina	11	6
15	NYU Langone Medical Center, New York	10	7
16	Mount Sinai Hospital, New York	10	6
17	Barnes-Jewish Hospital/Washington University, St. Louis	9	8

Improvement in Clinical TNM Staging Documentation Within a Prostate Cancer Quality Improvement Collaborative

Christopher P. Filson, Brooke Boer, Jon Curry, Susan Linsell, Zaojun Ye, James E. Montie, and David C. Miller

UROLOGY 83 (4), 2014



MCR SMH NSQUIP data

SS Thoracic ROR	278	12	4.32%	4.07%	3.47%	1.20	0.69	2.10		9	As expected
SS Urology Morbidity	390	15	3.85%	4.45%	7.76%	0.53	0.33	0.83	LOW	1	Exemplary

* Determined by Outlier status or by Decile status. When a Procedure Targeted model does not identify any statistical outliers, hospitals are not assigned to Needs Improvement, As expected, or Exemplary

** Predicted Observed Rate is the model-adjusted observed rate.

*** C.I.: 95% Confidence Interval.

Mayo Clinic Saint Marys Hospital

Site Number: 76

Page 3

Subspecialties - continued

	Total	Observed		Pred**	Expected	Odds	C.I.***		Outlier	Decile	Comment*
	Cases	Events	Rate	Obs. Rate	Rate	Ratio	Lower	Upper			
SS Urology Pneumonia	390	1	0.26%	0.70%	0.87%	0.80	0.42	1.54		1	Exemplary
SS Urology Renal Failure	390	3	0.77%	0.90%	0.97%	0.93	0.49	1.73		2	As expected
SS Urology UTI	390	2	0.51%	0.95%	1.95%	0.47	0.21	1.07		1	Exemplary
SS Urology SSI	390	8	2.05%	2.29%	2.83%	0.79	0.45	1.40		1	Exemplary



Conclusions

BAUS urologists are performing renal surgery with good outcomes comparable to colleagues across the pond

However, the bar in North America is too low

Central data reporting on both sides of the pond will be part of normal medical care

Must use caution to assure appropriate risk adjustment

Great potential for ongoing improvement, quality control, and cost savings

Thank You

