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Commentary: It takes a village: The next frontier in quality improvement

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In this issue of the *Journal*, Likosky and colleagues¹ describe a retrospective observational study of 83,747 cases of coronary artery bypass at 90 centers in 6 regional collaboratives. Rates of (1) complications, (2) operative mortality, and (3) failure to rescue (FTR), defined as death following a complication, were compared across hospital observed to expected mortality terciles. The data revealed significant interhospital variation in mortality, which was driven much more by FTR than by rate of complications. Further, FTR rate after major complications was not correlated with case volume. As the authors state, “interhospital variation in mortality is driven more by how a hospital manages complications than the rate of complications.”

In a quest to improve cardiac surgical care, surgeons have pursued additional training, developed procedural refinements, and improved both care algorithms and patient selection criteria. This has resulted in improved morbidity and mortality despite the ever-increasing comorbidity of our patients. Others have demonstrated significant institutional variation in outcomes.²⁻⁴ This study shows again that high-performing centers

CENTRAL MESSAGE

Reducing failure to rescue is the next frontier in quality improvement. This requires a team approach to care, development of new relationships with shared responsibilities, and new paradigms of care.

with low mortality do not have fewer complications but rather lower mortality in those who experience a complication.

Surgical outcomes are sometimes viewed as a reflection of surgeon competence. However, quality performance encompasses a range of processes. This study spotlights the next frontier in cardiac surgery quality improvement: institutional competence. Reducing complications is desirable. However, rate of complications is more likely due to patient comorbidities than to quality of hospital care.⁵⁻⁸ An important aspect of improving institutional performance is to reduce FTR rate. To accomplish this, hospitals first need a benchmark FTR rate for each procedure against which they may gage their institutional performance. To focus their quality-improvement efforts, they also need a benchmark for FTR after each individual complication. For example, they may excel at rescuing patients who suffer a stroke but fall behind in rescue after renal failure.

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As stated, quality encompasses a range of processes. Care of the patient is now a shared responsibility of stakeholders who have equal discretionary authority to make care decisions. The pathway to excellence likely involves elements of care that are not well archived and therefore not well studied. How, then, does an institution achieve excellence? The answer lies in a willingness to engage in new paradigms of processes and relationships. These certainly include, among others: elimination of competition between surgeons and subspecialization of procedures performed, open dialogue with team cardiologists during a preoperative conference, preoperative involvement of appropriate consultants for at risk patients, administration supportive of additional inpatient days spent attaining maximal medical optimization, use of a limited number of cardiac anesthesiologists who are accomplished transesophageal echocardiographers equipped with dedicated machines and probes, a care model that encompasses nurse practitioners and intensivists, and a dedicated cardiac quality surveillance team. Clearly, the responsibility for quality extends beyond the surgeon and its pursuit involves a dedicated team effort and supportive, involved administration. Let us commit ourselves to development of

the benchmarks needed and a relentless pursuit of excellence in which reducing failure to rescue is seminal.

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Commentary: Failure to rescue: What does it really measure?

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Likosky and colleagues¹ are to be congratulated for another meaningful contribution to the art and science of outcomes

Failure to rescue (FTR) is defined as operative mortality among patients developing postoperative complications. The quality of medical and surgical care will be advanced by improving the understanding of the complex relationship of operative mortality, postoperative complications, and FTR.

CENTRAL MESSAGE

Failure to rescue (FTR) is defined as operative mortality among patients developing postoperative complications. As a measure of quality, FTR will allow for more focused assessment of postoperative cardiothoracic surgical care.

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