Commentary: We have the opportunity to be above average

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Author and humorist Garrison Keller used to close his regular radio monologue with the tag, “That’s the news from Lake Wobegon, where all the women are strong, all the men are good-looking, and all the children are above average.” In this mythical place where everyone and everything seems uniquely above average, the cardiac surgery programs of Lake Wobegon would all clearly be performing better than expected.

In this issue of the Journal, Worrall and colleagues1 explore this notion, questioning whether every cardiac surgery program is indeed a high-performing program. Indeed, their multifaceted surgeon-led quality improvement initiative examined their cardiac surgery program in their health care system. What they found in 2014 is that the risk-adjusted observed mortality for coronary artery bypass grafting (CABG) was higher than expected. In plain language, they observed a signal that their outcomes for CABG were not as good as they had thought. With this recognition, they initiated a thoughtful, thorough, and health care system–wide initiative to improve their CABG mortality. In a 3-year period from 2014 to 2017, they demonstrated a 50% reduction in observed to expected mortality for CABG. The strengths of this analysis include (1) use of the Society of Thoracic Surgeons risk models and definitions for calculating expected mortality and morbidity with the use of risk-adjusted data; (2) surgeon-leaders who engaged a multifaceted key stakeholder process to provide ongoing support for this project; and (3) unblinding the data and requiring underperforming programs to provide written corrective action plans. In summary, this surgeon-led initiative challenged all programs in their health care system to monitor outcomes continuously and act on the data.

Outcomes of CABG are arguably some of the most rigorously examined quality metrics in medicine. Several different models of reporting and quality initiatives exist. The first of these models included mandatory reporting of CABG mortality in New York State.2 Several states now mandate public reporting of CABG mortality. A variety of regional, voluntary collaborative networks—The Northern New England,3 Michigan Society of Thoracic and Cardiovascular Surgeons,4 and Virginia Cardiac Surgery Quality Initiative5—all have coordinated and published quality initiatives that have led to system-wide improvements in coronary artery bypass outcomes. Finally, the Society of Thoracic Surgeons National Adult Cardiac Database serves as the widest and most far-reaching example of a quality improvement program, with more than 95% of programs in the United States reporting to the Society of Thoracic Surgeons database.6

We thus return to the notion that with honest and critical analyses of one’s cardiac surgery program, substantial improvements can be made to optimize outcomes. This report in the Journal offers a concrete example of how to effect change in a health care system. The first observation that Worrall and colleagues1 made is perhaps the most important. We cannot all perform better than expected. We all, however, have the opportunity to perform better than expected when we systematically analyze how we can improve and create actionable plans with accountability. With thoughtful analysis of risk-adjusted outcomes, we can offer our patients who undergo CABG the best chance for being alive and well.

References

