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FROM THE DESK OF THE PRESIDENT

The Importance of Outcomes Data

“If I don't do it, somebody else will...”

—Mac Robennack (Dr. John “The Night Tripper”)

How infuriating is it to learn that an insurance company has retroactively cut reimbursement 60% for one of your procedures because of their “medical policy” decision? Yet because of current contractual relationships, you as a physician have little recourse. Are we truly helpless? No, not really. In my November/December president's message, I discussed some of the challenges in the current health care environment and how outcomes research can be one solution. I would like to look a little more closely at this issue and how exactly outcomes can provide us with some potential solutions.

Evolution

The systematic and quantitative study of health outcomes is fairly recent. Approximately 30 years ago, this field started to garner the attention of researchers. Traditionally, physicians and researchers looked at objective physiological measures (like the results of lab tests) to decide if a treatment was needed and/or working. Researchers now realize that looking only at these kinds of indicators can cause us to miss many outcome issues that may matter most to patients and society. Driven by progress in the field of geriatrics and by studies such as the RAND Health Insurance Experiment,¹ interest in outcomes research has grown. This was further underscored by the discovery and documentation of geographical variations in practice by researchers in the early 1980s.² Researchers and physicians are now reaching out to find new ways to measure the effect of health care.³

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findings alone, while important, are often an insufficient measure of any intervention's impact. The study of health outcomes looks beyond the physiological measures of success to the effects of the health care process on patients and populations.²

An integral part of these health justifications is the evidence-based medicine (EBM) process. With the advent of EBM, expert opinion (except in the absence of valid evidence) is no longer enough reason to justify patient treatment. The existence of good quality medical evidence in a variety of forms, including outcomes research, has become even more important. Everything from quality patient care to reimbursement to physician performance and patient choice is now starting to be measured by the yardstick of evidence and rightly so. This is of particular relevance in the field of spine where there are embarrassingly large gaps in our evidence base.

Real World Examples

Outcomes data are used and collected by a variety of organizations from government agencies to third party payers and medical associations for many different purposes.

The Centers for Medicare and Medicaid Services (CMS) makes national coverage decisions for Medicare through an evidence-based process, with opportunities for public participation. In some cases, CMS' own research is supplemented by an outside technology assessment and/or consultation with the Medicare Coverage Advisory Committee (MCAC).⁴ MCAC provides CMS with advice on scientific, clinical practice and ethical questions regarding Medicare coverage issues. MCAC looks at whether an intervention will improve the health of Medicare beneficiaries using sources of evidence that

might include peer-reviewed scientific literature and unpublished data used to secure FDA approval—both of which could be the result of, or influenced by, outcomes research.⁵ NASS recently participated in an MCAC meeting to discuss the evidence for fusion for degenerative disc disease. Possessing outcomes data relative to spine in these circumstances would be beneficial for patients, spine care physicians and NASS. Unfortunately, commercial insurance carriers often extrapolate CMS decisions, take them out of context and erroneously apply them to all of their insured.

Supporting improvements in health outcomes is also a strategic goal of the governmental Agency for Healthcare Research and Quality (AHRQ), who sponsors and performs outcomes research. For example, AHRQ-sponsored outcomes studies have shown that even when treatments are known to be effective, many people who could benefit from them are not getting them. Beta blocker medication, given after heart attacks, can reduce mortality; blood thinning medication can prevent strokes; and thrombolytic therapy given immediately after a heart attack can reduce the damage from the attack. Yet many eligible patients are not getting treatment. By identifying and addressing the barriers to better care—for example, through development of a tool to help doctors know which patients with suspected heart attacks will benefit from thrombolytic treatment—AHRQ researchers have helped translate findings into practical strategies to improve care.³

Third party payers and employers are also very interested in patient outcomes in order to help their patients make good care decisions that help the bottom line. Pharma and device companies regularly conduct research and engage research organizations to help them generate outcomes data for FDA approvals.

Some physician organizations have entered the outcomes data collection arena as well. The most well-known of these is the Society for Thoracic Surgeons (STS) who, almost 20 years ago, entered

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the game on the basis of improving quality patient care and is now heading a \$12 million outcomes data project that influences patient care, reimbursement and performance measurement.

The efforts of the Thoracic Surgeons have focused chiefly on prevention of postsurgical complications. This is distinct in focus from the functional outcome measures more often targeted in spine care. There is no doubt that the STS program has improved patient care, largely by addressing complications, although in the process some thoracic surgery programs have been closed.

Many of us are also familiar with American Academy of Orthopaedic Surgeons' MODEMS (ie, Musculoskeletal Outcomes Data Evaluation and Management System) project, which although not successful, was a step in this direction. The bariatric surgeons and the American Association of Neurological Surgeons/Congress of Neurological Surgeons also have initiated projects to collect outcomes data in their fields.

At some point in the not so distant future, as a condition of maintenance of certification, it is possible that we all may be required to collect data as proof of efforts at quality improvement. This is being required on a specialty-by-specialty basis for now, but seems to be the direction of the future.

NASS' Role

NASS is determined to enter the outcomes data collection game in some fashion. We are currently investigating the means by which we can enter this arena in the most cost-efficient and successful way possible to benefit both patient care and physician members. We are examining different ways to generate useful

data from mining existing databases to undertaking our own research project or piggybacking on to the efforts of another group. We will keep in mind foremost the multidisciplinary nature of membership and try to make our lives easier, not harder. It is only by providing such data that we spine care providers will be able to maintain practice autonomy. If we don't, we have no one to blame except ourselves. Watch for a survey on this topic which is coming your way.

In the meanwhile, the next time you buy something at a department store, tell the salesperson it is your "personal policy" to pay only 40% of the recommended price. Then call one of the commercial health insurance carriers for your jail bond!!! They will understand!!!

References

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