Hello everyone and welcome to the first PSQC webinar! We really appreciate your continued interest in this collaborative and look forward to getting started. First we will start with a few housekeeping reminders:

1) To reduce the likelihood of feedback during the call, we’ve muted everyone.

2) Please use the chat function to ask questions. We have time at the end of the presentations to respond to any questions submitted during the webinar, and, we’ll open to a Q&A format at the end.

3) The webinar is being recorded. We will post it later and provide a link so you can review or share with any member of your team unable to be on the call. Please frame any questions with the understanding it will be part of the recording.
Here is our agenda for today.

1) A broad overview of the PSQC
   1) What is a quality improvement collaborative?
   2) Our mission
   3) Our proposed structure
   4) Our admin team members and executive committee members
   5) Who are our current members
   6) Data source

2) How do other surgical quality collaboratives operate?
   1) Our colleagues from the Michigan Surgical Quality Collaborative will provide us some insight into how their QC works

3) Quality improvement in healthcare setting
   1) Model for improvement and PDSAs
   2) Research vs. QI
   3) Discuss the opportunity for more formalized QI training for those PSQC members who may want it
1) A review of our first project
   1) Implementation committee composition
   2) How the project was selected

2) Intervention Development
   1) Use of an intervention bundle
   2) Participating site time commitment
   3) Proposed timeline for first project

3) Next steps

4) Q&A
The mission of the PSQC is to develop a national partnership of children’s hospitals, surgical providers, and the American College of Surgeons who share the mission of delivering high quality, cost effective, patient-centered surgical care.

Recognizing a gap in surgical quality collaboratives for pediatric populations, the Pediatric Surgery Quality Collaborative (PSQC) has as its primary purpose the improvement of patient outcomes in specific surgical procedures, through use of quality improvement methodology and implementation science. The PSQC will capitalize on data provided to the ACS NSQIP to identify areas of improvement opportunity and launch
PSQC operational structure
The PSQC is led by Dr. Kevin Lally. Dr. Lally is the A.G. McNeese Chair, Richard J. Andrassy Distinguished University Chair, Professor and Chairman of the Department of Pediatric Surgery. He is Surgeon-in-Chief of the Children’s Memorial Hermann Hospital. Terry Fisher is the program manager. Ms. Fisher holds a MPH from Chapel Hill and has worked in hospital administration, operations and research for over 10 years. She will support the operational and implementation functions of the PSQC. The PSQC budget does allow for additional program coordinator support and data analytics in the future as the program matures.

Dr. Lally envisioned the PSQC and worked for some time on making it a reality. He solicited input and participation from a broad array of pediatric surgeons across the country. Those surgeons comprise the members of our executive committee. The EC functions as the advisory board for the direction and operation of the PSQC. Our members are well respected pediatric surgeons with quality improvement experience.
Our EC members are:
1. Dr. Doug Barnhart, Primary Children’s, Salt Lake City
2. Dr. Loren Berman, Nemours Alfred I. duPont Hospital for Children, Wilmington
3. Dr. Cindy Downard, Norton Children’s, Louisville
4. Dr. Mary Fallat, Norton Children’s, Louisville
5. Dr. Brian Kenney, Nationwide Childrens, Columbus
6. Dr. Max Langham, Le Bonheur, Memphis
7. Dr. Keith Oldham, Children’s Wisconsin, Milwaukee
8. Dr. Dan Ostlie, Phoenix Children’s, Phoenix
9. Dr. Shawn Rangel, Boston Children’s, Boston
10. Dr. Mehul Raval, Lurie Children’s, Chicago
11. Dr. KuoJen Tsao, Children’s Memorial Hermann, Houston
As of today, we have 38 member hospitals from 19 states.
List of all PSQC members

<table>
<thead>
<tr>
<th>State</th>
<th>Members</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>Children's Alabama-Rob Russell</td>
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<tr>
<td>Arkansas</td>
<td>Arkansas Children's-Sid Dossinger</td>
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<td>Arizona</td>
<td>Phoenix Children's-Justin Lee</td>
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<tr>
<td>California</td>
<td>Children's Los Angeles-Lorraine Kelly-Kwon</td>
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<td>Children's Orange County (MCoC) Ygitt Gurer</td>
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<td>Kaiser (Fontana), CA) - Donald Shaul</td>
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<td></td>
<td>Lucille Packard Children's-Steve Sheey</td>
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<td>UC Davis Children's-Skin Hirose</td>
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<td></td>
<td>Valley Children's-Jim Pierce</td>
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<tr>
<td>Connecticut</td>
<td>Connecticut Children's-Christine Finck</td>
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<tr>
<td>Delaware</td>
<td>Nemours/Alfred I. DuPont Children's-Loren Berman*</td>
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<tr>
<td>Florida</td>
<td>Joe DiMaggio Children's - Holly Neveil</td>
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<td></td>
<td>Johns Hopkins All Children's - Raquel Gonzalez</td>
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<td>Wolfson Children's - Dan Roble</td>
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<tr>
<td>Illinois</td>
<td>Comer Children's - Mark Sladell</td>
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<td>Lurie Children's-Mehul Rawai*</td>
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<tr>
<td>Kentucky</td>
<td>Norton Children's-Cindy Downard*</td>
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<tr>
<td>Massachusetts</td>
<td>Boston Children's-Shawn Rangel*</td>
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<tr>
<td>New York</td>
<td>Cohen Children's-Jose Prince</td>
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<td>Golisano Children's-Derek Wademan</td>
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<td>John Oishei Children's - David Rothsstein</td>
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<tr>
<td>Ohio</td>
<td>Akron Children's-Rob Parry</td>
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<td>Cincinnati Children's-Aaron Garrison</td>
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<td>Nationwide Children's-Brian Kenney*</td>
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<td>Rainbow Babies-Anne Kim Mackow*</td>
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</tbody>
</table>
List of all PSQC members

PSQC Members^  

Pennsylvania  
Penn State Children’s- Bob Olley  

Tennessee  
Le Bonheur Children’s-Regan Williams  
Vanderbilt Children’s- Martin Blakely  

Texas  
Children’s San Antonio-John Doolk  
Cook Children’s-Issel Iglezias  
UT Dell Children’s- Nilda Garcia  
Children’s Memorial Hermann-Kuolen Tsao*  
Texas Children’s Hospital (TCM)- Monica Lopez  

Utah  
Primary Children’s-Doug Barnhart*  

Virginia  
King’s Daughters Children’s-Michael Goresky  

Washington  
Mary Bridge Children’s-Tony Escobar  
Seattle Children’s- Adam Goldin  

Wisconsin  
Children’s Wisconsin- David Gourlay  

^as of July 10th  
*EC
Ms. Fisher will be creating interventions and training, in collaboration with the PSQC executive committee, implementation committee and Memorial Hermann QI specialists for each project the PSQC undertakes. The PSQC is making use of the existing data submitted to ACS NSQIP. We receive a SAR for the collaborative members at same time as members receive their SAR. The PSQC will also receive the negative appendectomy vs. preoperative CT rates chart for collaborative members from the targeted appy report. These blinded SARs will be accessible on the PSQC website for PSQC participating sites and their team members.
“Great... just what we need: another quality-improvement campaign!”
We are now joined by Kathy Bishop, operations director of the MSQC. Ms. Bishop joined MSQC in July 2017 after spending three years as the Program Manager for the Michigan Surgical Health & Optimization Program (MSHOP).

Most of us are familiar w/the Michigan model. Ms. Bishop will provide a brief history of the MSQC and an operational overview. Please join me in welcoming her.
MSQC History:

- 2005
- Compare data, improve quality, safety and value
- Promoting data-driven best practice
- NSQIP registry, moved to custom
- Use data to examine reasons for variation in quality
- Best performing hospitals share what works
- Collegial, non-competitive, and evidence-based
MSQC Today:

- 70 hospitals
- 50,000 cases per year
- Over 700,000 cases in database
- General surgery, vascular surgery, gynecology
- 120 clinical nurse reviewers
- 2500 Surgeons
- Supported entirely by BCBSM, Michigan’s largest insurer, one of 17 CQI’s
The two main quality improvement programs

Programs:

• Pay for Performance
  • Uplift based on hospital revenue
  • Hospital’s receive a scorecard for each CQI
  • 70% performance/30% participation
  • MSQC is a required CQI
  • Yearly quality improvement projects

• Value Based Reimbursement
  • Physician Fee uplift
  • Measures compliment quality improvements at the hospital efforts
Opioid consumption and patient reported outcomes in Michigan after surgery
Overview
 Lets take 5 minutes now to ask any questions. Please type them in the chat box.

Thank you again for agreeing to join us and share your experience. We can only hope to be as successful as you’ve been. For those of you who’s questions could not be addressed, we’ll bring them to Ms. Bishop later and then share the responses broadly.
Whoa, whoa! Knock over the mug, not the coffee pot. You're a lovable jerk, Dave, not a barbarian.

CAT IN TRAINING
As we are a quality improvement collaborative, wanted to review the basics of what that means. In health care, quality improvement (QI) is the framework we use to systematically improve the ways care is delivered to patients. Processes have characteristics that can be measured, analyzed, improved, and controlled. QI entails continuous efforts to achieve stable and predictable process results, that is, to reduce process variation and improve the outcomes of these processes both for patients and the health care organization and system. Achieving sustained QI requires commitment from the entire organization, particularly from top-level management.

The IHI Model for Improvement is the most commonly used QI approach in healthcare. The MFI uses a rapid cycle process called Plan Do Study Act (PDSA) cycles to test the effects of small changes, make them, and ultimately spread the effective changes through the practice or organization. We will be using this approach in our projects.
Quality improvement should not be confused with research although it’s easy to do. They have many overlapping activities. This comparative chart from CHoP is a good tool for assessing whether your project is QI or research.

<table>
<thead>
<tr>
<th></th>
<th>Human Subjects Research</th>
<th>Quality Improvement</th>
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<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>designed to develop or contribute to generalizable knowledge</td>
<td>designed to implement knowledge, assess a process or program as judged by established accepted standards</td>
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<tr>
<td><strong>Starting Point</strong></td>
<td>knowledge-seeking is independent of routine care and intended to answer a question or test a hypothesis</td>
<td>knowledge-seeking is integral to ongoing management system for delivering health care</td>
</tr>
<tr>
<td><strong>Design</strong></td>
<td>follows a rigid protocol that remains unchanged throughout the research</td>
<td>adaptive, iterative design</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>might or might not benefit current subjects; intended to benefit future patients</td>
<td>directly benefits a process, system or program; might or might not benefit patients</td>
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<tr>
<td><strong>Risks</strong></td>
<td>may put subjects at risk</td>
<td>does not increase risk to patients, with exception of possible patients’ privacy or confidentiality of data</td>
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<tr>
<td><strong>Participant Obligation</strong></td>
<td>no obligation of individuals to participate</td>
<td>responsibility to participate as component of care</td>
</tr>
<tr>
<td><strong>Endpoint</strong></td>
<td>answer a research question</td>
<td>improve a program, process or system</td>
</tr>
<tr>
<td><strong>Analysis</strong></td>
<td>statistically prove or disprove hypothesis</td>
<td>compare program, process or system to established standards</td>
</tr>
<tr>
<td><strong>Adoption of Results</strong></td>
<td>little urgency to disseminate results quickly</td>
<td>results rapidly adopted into local care delivery</td>
</tr>
<tr>
<td><strong>Publication/Presentation</strong></td>
<td>investigator obliged to share results</td>
<td>QI practitioners encouraged to share systematic reporting of insights</td>
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</table>
The PSQC admin team will be providing in depth QI training for those who are interested. These trainings will be provided via webinar. The sessions will be recorded and archived on the PSQC website for use by anyone.
EXCUSE ME, FRED. MY LACK OF OBEDIENCE TRAINING HAS ONCE AGAIN MANIFESTED ITSELF. JUST MOMENTS AGO, I CHEWED UP YOUR FANCY PILLOWS AND POOPED IN YOUR SHOE.

ON THE PLUS SIDE, FRED HAD DONE A FINE JOB OF TRAINING MR. BARKLEY TO SPEAK.
Dr. Raval chairs the Implementation Committee. This committee is charged with reviewing the available data from the SARs and identifying a project with the potential for improvement through a quality improvement approach.
The IC members are:
1) Loren Berman, DuPont
2) Anne Kim, Rainbow
3) Monica Lopez, TCH
4) Shawn Rangel, Boston Children’s
5) Steve Shew, Packard
6) KuoJen Tsao, CMHH
The executive committee met April 24th and reviewed the data from the collaborative SAR released in Feb 2020. The EC agreed the first project to explore would be reducing SSI and OS SSI in complicated appendectomies. You can see there is opportunity for improvement in these categories. At the time this data was shared, we had 31 collaborative members. We now have 38 members with executed DUAs. We anticipate the next SAR will be similar.
As part of the QI process, the IC looked at the SARs and identified a project that is common across all member sites and has the volume to demonstrate a profound impact a practice change would affect. The IC has proposed we conduct a series of qualitative interviews of both the high performers and low performers to assess each site’s standard approach in this cases. The interviews will be recorded and coded to identify trends. QI intervention bundles will be developed based on these findings.
In addition to the primary objective of our first project, a potential secondary effect on reduction in ionizing radiation may also be achieved.
“Have you tried icing it?”
So, now that we’ve explained how we went about selecting our first project, let’s discuss how we plan to go about creating our first intervention bundle. In compliance with the DUAs each of your institutions executed, the PSQC SAR is unblinded to the admin group-Dr. Lally and Ms. Fisher. We can see who is identified as exemplary and who is needs improvement on our metric of choice. Dr. Lally reached out personally to each of them and asked their permission to unblind them to the IC so that the IC could conduct a qualitative interview of each one.

We’ll compare the trends identified with the literature and validated best practices to highlight what clinical or operational practice at our Exemplary sites seem to correlate with less SSI. We will solicit subject matter experts in this area for advice on what action might produce the best results in a QI project.
The intervention bundle will contain the following: an overview and rationale for project; change strategies you might use; measures to gauge your progress; toolkits and resources; and the actual guide on what focus your QI efforts should take. The implementation will be released to all PSQC members with a training associated with its use. The training will be recorded and posted on the PSQC website for access to those unable to attend the ‘live’ training and to provide training as new members join your team and serve as a refresher.
This our proposed timeline for the rest of 2020. As you can see from the timeline, it will take several SAR cycles before we are likely to see any change in the SSI outcome. The challenge with using the SAR is that unlike most QI projects, which are intended to provide rapid improvement, our feedback loop will be substantially delayed.
It may take some time before we see movement on the outcome. We may ultimately not see any change.
Ms. Fisher will meet with site teams monthly to provide support on the implementation tool or guidance, and assist with PDSA cycles. Ms. Fisher will also work with your site SCRs to engage them in the project and assist with any questions.
For those of you who have not yet completed the intake survey, Terry will be following up with you directly. We anticipate the next collaborative SAR to be released around July 23rd. The IC will review it, compare to the last SAR we received, and then identify those sites for the qualitative interviews.

The monthly check-ins will start in September, after Labor Day. Terry will reach out in advance to find a time that works for you. We may eventually set regional groups and take advantage of some regional meetings the ACS may sponsor to meet in-person. If those days ever return. 😊

A follow-up webinar will be conducted in late August for the SCRs specifically. More to come on that.

Once we have everyone’s feedback on who might like additional training in QI methodology, webinars will be created and presented. Anticipate those starting in late September.

At the conclusion of today’s webinar you’ll receive a survey for you to provide feedback on what you liked and didn’t like about this webinar as well as an opportunity for you to share ideas for future meetings. We anticipate our next webinar will be in mid-October. By
Monday July 21 you’ll receive a link to the recording of this webinar. You are welcome to share the link with whomever you think might benefit from review of the webinar.
Questions?