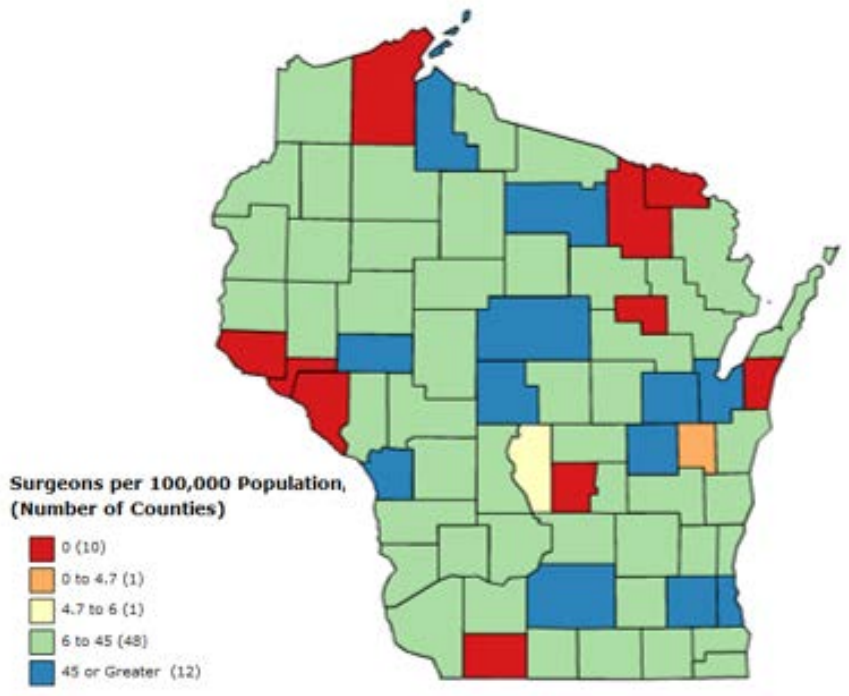
Improving Access to High Quality, Cost-Effective Surgical Care:

SURGICAL COLLABORATIVE OF WISCONSIN

Surgical Procedures in Wisconsin

- 129 non-federal general med-surg hospitals[1]
- 74% outpatient surgeries (492,039)
  26% inpatient (169,823)[1]
- Rural state
  - 65% of counties rural (47/72)
  - 14% (10) no surgeons[2]
  - 28% (20) fewer than
    20 surgeons per 100,000 pop[2]
- QI efforts must not exacerbate health inequities



1. Wisconsin Hospital Association Information Center. Guide to Wisconsin Hospitals: Fiscal Year 2015. Madison, WI: September 2016.
2. The American College of Surgeons Health Policy Research Institute, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Data Source: AMA Physician Masterfile, effective date October 2011; Census 2010, US Census Bureau. Data include non-federal, non-resident, clinically active physicians less than 80 years old. For more information on classification of specialties, see http://www.acshpri.org/atlas/loadflash.php?s=102

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Surgical Quality Collaboratives

Collaboratives Increase Quality and Reduce Costs

- Michigan collaboratives demonstrated a 50-60% improvement in outcomes
  - Postoperative complications, mortality, readmission
  - Documented savings of $20 million per year
- Tennessee collaborative reduced postoperative mortality 31%
  - Documented savings of $29 million over 4 years

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Michigan Surgical Collaboratives are Inclusive

- Statewide collaboratives aim to improve quality across *all* providers and hospitals (in contrast to volume-based referral or accreditation QI efforts)

Overview Of Four Regional Collaborative Improvement Programs In Michigan

Characteristic	Percutaneous coronary interventions	Cardiac surgery	Bariatric surgery	Major general and vascular surgery
Program start	1998	2006	2006	2005
Current number of hospitals (percent eligible)	31 (100%)	33 (100%)	27 (96%)	34 (94%)
Approximate number of patients per year*	32,000	10,000	7,000	50,000
Cost to BCBSM/BCN per year	$3.2 million	$3.0 million	$2.7 million	$5.0 million
Registry	Locally developed	STS registry with local enhancements	Locally developed	ACS-NSQIP with local enhancements

SOURCE Blue Cross and Blue Shield of Michigan. **NOTES** BCBSM/BCN is Blue Cross and Blue Shield of Michigan/Blue Care Network. STS is Society of Thoracic Surgeons. ACS-NSQIP is American College of Surgeons National Surgical Quality Improvement Program. Although approximately 100,000 Michigan patients each year undergo general and vascular procedures targeted by ACS-NSQIP, this registry collects data on a random subset. *Patients per most recent year (2010).

SCW ***Mission Statement***

SCW is a practice change community that aims to optimize quality and reduce costs by improving surgical care and fostering provider professional development across practice settings

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Objectives

1. Ensure equal access to high-quality surgical care in communities across Wisconsin

2. Promote appropriate utilization of surgical care and control costs

3. Provide a performance improvement platform for Wisconsin surgeons

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SCW Funding Update

- Internal WISOR Resources
- UW AAA Department of Surgery
- Gunderson Foundation
- Wisconsin Partnership for Patients (WPP)
- Potential:
  - ACS Advocacy Funds
  - CDC Opioid Funds
  - State Funds

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Barriers in Wisconsin

- State quality initiatives focus on primary care with little attention to specialty care
- Lack of major payer like BCBS
- Limited number of hospitals participate in NSQIP (< 10)
- Lack of integrated data infrastructure to facilitate QI and research initiatives
- Need to identify partners with similar mission and synergistic activities

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Facilitators in Wisconsin

- Wisconsin at forefront of efforts to measure health care performance (e.g., WHIO, WCHQ)[1]
- Wisconsin Surgical Society (WSS) engages practicing surgeons in the state who are anxious to engage in QI and research and have a track record of doing so
- WSS has active Quality and Research Committee with appropriate expertise
- WiSOR (Wisconsin Surgical Outcomes Research Program) has the resources and expertise to provide a coordinating center
- Data partners (WHA/WHIO) provide a robust data resource

1. Toussaint J, Shortell S, Mannon M. Improving the value of healthcare delivery using publicly available performance data in Wisconsin and California. Healthcare. 2014: 85-89.

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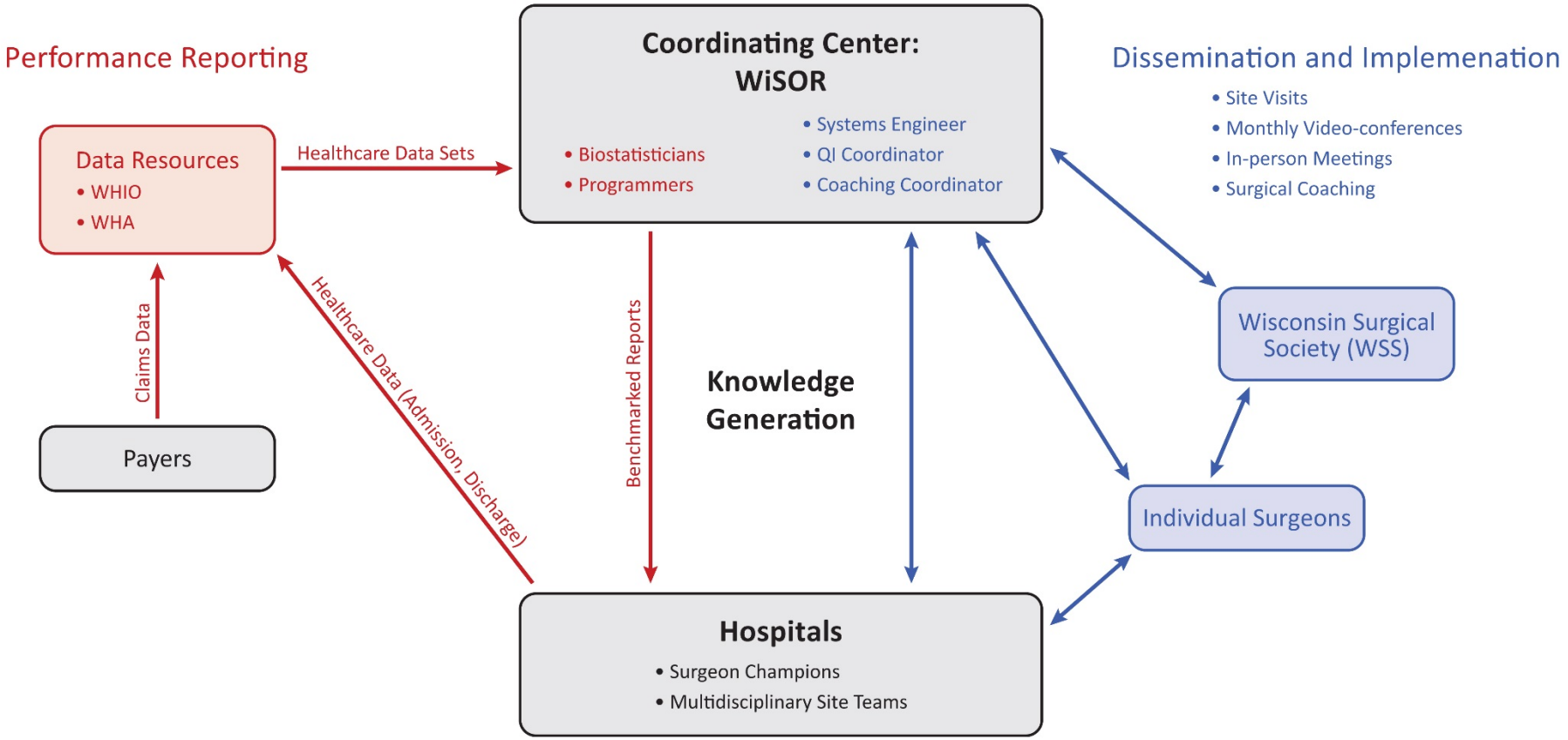
Surgical Collaborative of Wisconsin (SCW)



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SCW Inaugural Initiatives

- Reducing Repeat Breast Cancer Surgeries
- Improving Colorectal Surgery Quality of Care and Outcomes
- Addressing Opioid Prescribing and Alternative Pain Management Options

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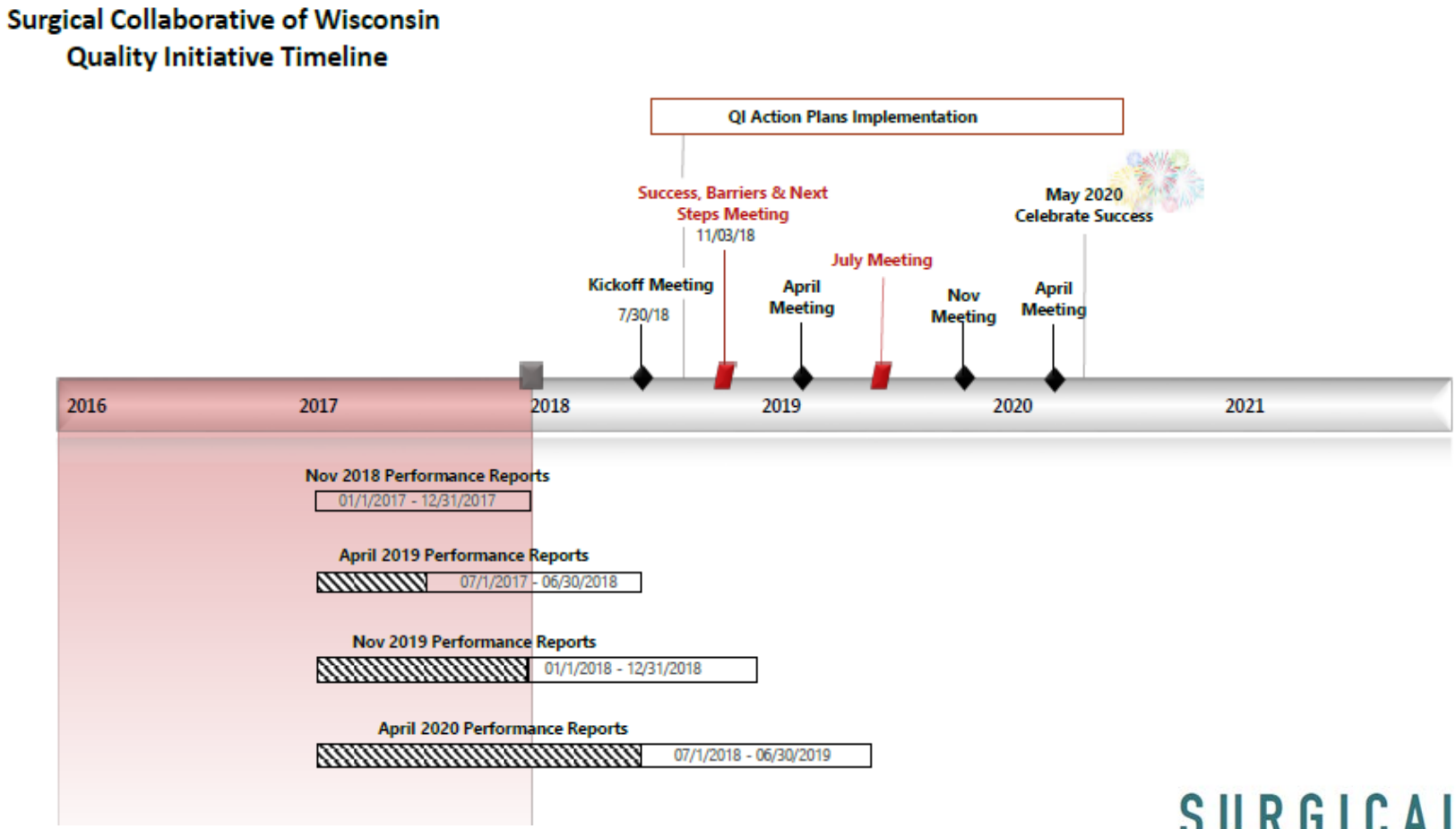
Initiative Timeline



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QI Approach

- Disseminate best practices
  - Provide overview of practice guidelines
  - Review supporting literature
- Provide performance reports
  - Institution v surgeon level
  - Longitudnal performance tracking
- Set action plans and goals
  - Individual QI approach
  - Define and measure success

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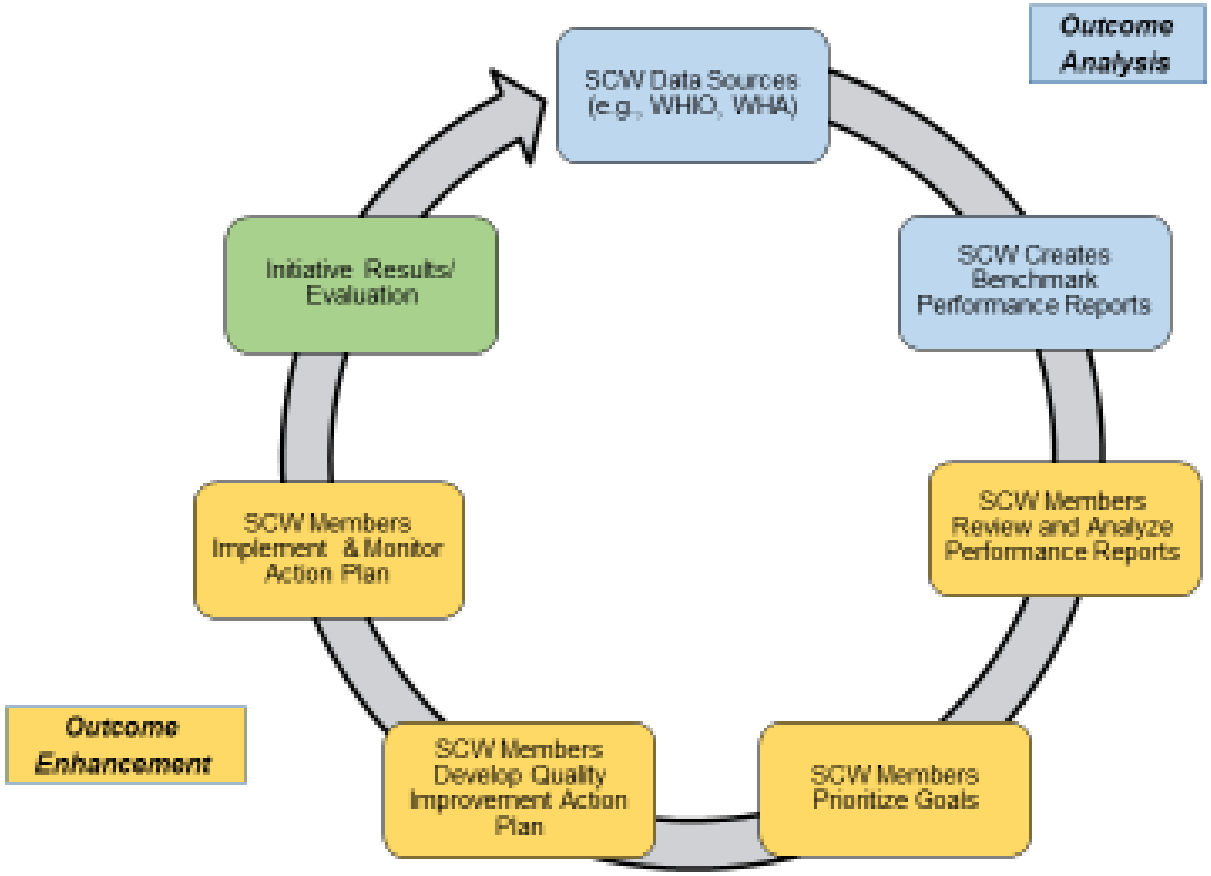
Outcome-Based Quality Improvement



Adapted from Centers for Medicare and Medicaid Services. Outcome-Based Quality Improvement (OBQI) Manual. 2010.

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Best Practices

Reducing Repeat Operations for Women with Breast Cancer

SSO/ASTRO Guidelines on Margins for BCS

Margin Status	Stage I or II Invasive Breast Cancer (+/- DCIS)	DCIS Alone (no invasion)
Positive Margin (tumor on ink)	Re-excise	Re-excise
Close Margin (<2mm)	No further surgery	Re-excise
Negative Margin (2mm or greater)	No further surgery	No further surgery

*Recommendations are not influenced by systemic treatment, receipt of WBRT, tumor biology, or other factors.

Stage I and II Invasive Breast Cancer (+/- DCIS). A positive margin, defined as ink on invasive cancer or ductal carcinoma in situ (DCIS), is associated with two-fold increase in IBTR. This increased risk is not nullified by: delivery of a boost dose of radiation, delivery of systemic therapy (endocrine therapy, chemotherapy, or biologic therapy), or favorable biology. Wider margin widths do not significantly lower this risk. The routine practice to obtain wider negative margin widths than no ink on tumor is not indicated.

DCIS (No invasive cancer). Margins of at least 2 mm are associated with a reduced risk of IBTR relative to narrower negative margin widths in patients receiving WBRT. The routine practice of obtaining negative margin widths wider than 2 mm is not supported by the evidence.

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Procedure	Hydrocodone (Norco) 5 mg tablets Codeine (Tylenol #3) 30 mg tablets Tramadol 50 mg tablets	Oxycodone 5 mg tablets Hydromorphone (Dilaudid) 2 mg tablets
Laparoscopic Cholecystectomy	15	10
Laparoscopic Appendectomy	15	10
Inguinal/Femoral Hernia Repair (open/laparoscopic)	15	10
Open Incisional Hernia Repair	30	20
Laparoscopic Colectomy	30	20
Open Colectomy	30	20
Ileostomy/Colostomy Creation, Re-siting, or Closure	40	25
Open Small Bowel Resection or Enterolysis	30	20
Thyroidectomy	10	5
Hysterectomy		
Vaginal	20	10
Laparoscopic & Robotic	25	15
Abdominal	35	25
Breast Biopsy or Lumpectomy Alone	10	5
Lumpectomy + Sentinel Lymph Node Biopsy	15	10
Sentinel Lymph Node Biopsy Alone	15	10
Simple Mastectomy ± Sentinel Lymph Node Biopsy	30	20
Modified Radical Mastectomy or Axillary Lymph Node Dissection	45	30
Wide Local Excision ± Sentinel Lymph Node Biopsy	30	20

The material on this card is reprinted with permission from the Opioid Prescribing Engagement Network (OPEN) and Michigan Surgical Quality Collaborative (MSQC). Visit opioidprescribing.info for additional information.

Components of Enhanced Recovery Protocols

Preoperative	Intraoperative	Postoperative
• Patient education and expectation setting • Mechanical bowel preparation and oral antibiotics • Preoperative bathing • Carbohydrate loading • Clear liquid diet allowed until 2 hours before surgery • Multimodal pre-anesthesia analgesics and anti-emetics • Glucose control • Normothermia	• Laparoscopic approach • Prophylactic antibiotics (choice, timing, weight-based dosing and re-dosing) • VTE prophylaxis • Skin preparation with an alcohol-containing agent • Regional anesthesia (epidural, spinal, transversus abdominus plane (TAP) block) • IV anesthetics • Normothermia • Goal-directed fluid management (euvolemia) • Avoidance of nasogastric tubes and drains	• VTE chemoprophylaxis • Multimodal opioid-sparing analgesic regimen • Early initiation of diet • Early and progressive ambulation and mobilization • Early foley catheter removal • Minimize IVF

Performance Reports

Draft Performance Report Content

Enhanced Recovery Protocol for Colorectal Procedures

Table 1. Unadjusted length of stay and 30-day readmission*

	Hospital X	Participating Hospitals (n=)	All WI Hospitals (n=)
Median length of stay (IQR)			
Mean length of stay (SD)			
All-cause 30-day readmission			

*Patients who were transferred post-operatively (n=x) or who died during the inpatient stay (n=x) are removed from all length of stay calculations.
** IQR = interquartile range; SD = standard deviation

Table 2. Risk- and reliability-adjusted median length of stay and predicted probabilities of prolonged length of stay in Hospital X compared to SCW hospitals and all Wisconsin hospitals.

	Estimate (95% CI)
Hospital X	
Median Length of Stay	
Average Predicted Probability of Prolonged Length of Stay	
Participating Hospitals	
Median Length of Stay	
Average Predicted Probability of Prolonged Length of Stay	
Wisconsin Hospitals	
Median Length of Stay	
Average Predicted Probability of Prolonged Length of Stay	

* Probability of a prolonged length of stay, adjusting for patient risk factors and hospital volume.

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Action Planning

Colorectal Surgery Quality Initiative: Prioritization of Enhanced Recovery Components

Directions: Each component of the enhanced recovery protocol is listed in the first column. Use the test questions to help you prioritize your areas of interest. The goal is to identify 1-3 that will be the focus of your initial efforts. Once you have completed the prioritization, use the worksheet to develop an action plan.

Component of Enhanced Recovery Protocol	Strength of Evidence for Effectiveness (high, med, low)	Determine Priority	Rank Priority Order (1-3)
Preoperative			
Patient education and expectation setting		*Worth doing?* Yes No *Measureable?* Yes No *Improve outcomes?* Yes No *Fits with facility/practice culture?* Yes No	
Mechanical bowel preparation and oral antibiotics		*Worth doing?* Yes No *Measureable?* Yes No *Improve outcomes?* Yes No *Fits with facility/practice culture?* Yes No	
Preoperative bathing		*Worth doing?* Yes No *Measureable?* Yes No *Improve outcomes?* Yes No *Fits with facility/practice culture?* Yes No	
Carbohydrate loading		*Worth doing?* Yes No *Measureable?* Yes No *Improve outcomes?* Yes No *Fits with facility/practice culture?* Yes No	
Clear liquid diet allowed until 2 hours before surgery		*Worth doing?* Yes No *Measureable?* Yes No *Improve outcomes?* Yes No *Fits with facility/practice culture?* Yes No	
Multimodal pre-anesthesia analgesics and anti-emetics		*Worth doing?* Yes No *Measureable?* Yes No *Improve outcomes?* Yes No *Fits with facility/practice culture?* Yes No	
Glucose Control		*Worth doing?* Yes No *Measureable?* Yes No *Improve outcomes?* Yes No *Fits with facility/practice culture?* Yes No	
Normothermia		*Worth doing?* Yes No *Measureable?* Yes No *Improve outcomes?* Yes No *Fits with facility/practice culture?* Yes No	
Intraoperative			

Today's Agenda

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Member Meeting

Date: Monday, July 30, 2018 **Time**: 9:00 am – 315 pm

Time:		Leads:
9:00 – 9:30	Networking Breakfast	
9:30-9:40	Welcome to Gundersen	Dr. Jeff Landercasper
9:40-10:00	SCW Update • Funding update • Initiative update • Schedule for the day	Dr. Caprice Greenberg
10:00-11:00	SCW Table Strategy Discussions	Led by Executive Committee Members
Break	11:00 -11:15	
11:15 – 12:15	Working Lunch • Performance Report Overview • Performance Report Distribution	Dr. Jessica Schumacher
12:15 – 2:40pm	Initiative Breakout • Breast – 12:15 – 1255 – Dr. Jeff Landercasper • Colorectal – 1:10 – 1:50 – Dr. Elise Lawson • Opioid - 2:00 – 2:40 – Dr. Jonathan Kohler	Led by Surgeon Initiative Leaders
2:45 – 3:15	Wrap Up and Next Steps	Dr. Caprice Greenberg
3:15 – 3:30	Breast Re-Operation Validation Study Working Group (Optional)	Dr. Jeff Landercasper

Where do we go from here?

- Regular meetings to move the initiatives along and support members
  - Next meeting: November WSS in Kohler
- Expand tele-communicaitons
- Additional initiatives when appropriate
- Advocate for surgical collaboratives

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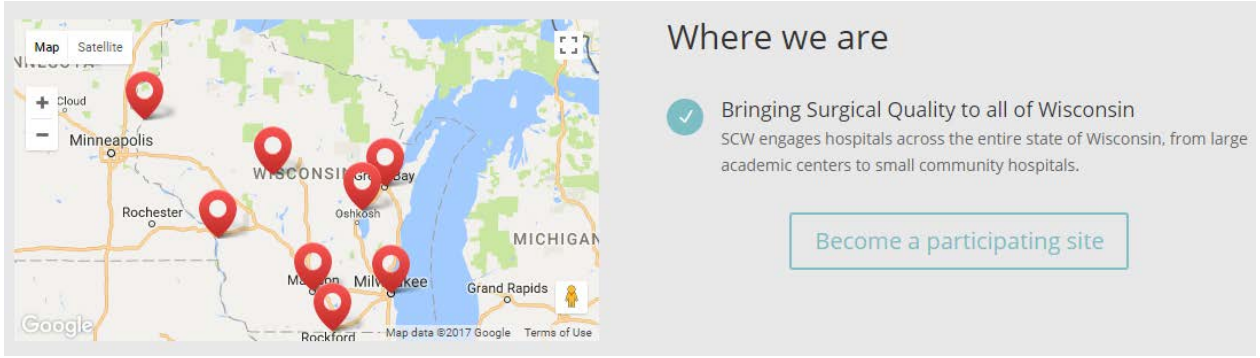
https://www.scwisconsin.org/



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Strategy Discussion

Process

- 5-8 people per table
- Please look at your name tag for your first table assignment
- Your table host will welcome you and a designated scribe will keep notes
- All ideas will be recorded and discussed
- At the end of 15 minutes of conversation and dialogue about the question posed, join another table. (Only the host and scribe remain at the table.)
- Please join another table with people that were not part of the first table discussion
- The hosts report out after a 5-minute break
- We are audio recording the table discussions

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Questions

1. What does success look like for SCW? For your own practice? For your institution?
2. What are potential barriers to involvement for surgeons? For quality leaders?
3. Should SCW be focused on general surgery and its subspecialties, or should we expand to other specialties? If we should expand, what areas would you suggest?
4. In what ways can SCW support your work between today and our next meeting on November 3?
5. What future quality initiatives or topics would you like to see SCW address?

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