2024 Quality Improvement Summit

Incorporating the QC in My Practice – Lessons Learned and Advice for Others

Winnie Henderson MD, PhD, FACS, CGRA
ACHQC QI Committee
March 24th , 2024

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ABDOMINAL CORE HEALTH QUALITY COLLABORATIVE

2023 Quality Improvement Summit

Getting the Most Out of the QC in Community & Private Practice: Tips & Tricks on How to Incorporate the QC workflow for Data Entry and How I Market Myself Using the QC

Winnie Henderson MD, PhD, FACS, CGRA
ACHQC QI Committee
March 4th , 2023

Oregon Surgical Wellness

2023 Quality Improvement Summit

- ACHQC Website
- Abdominal Core Surgery Rehab
- ACHQC Mobile App
- Patient Informational Flyers
- Marketing & Data Entry

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Oregon Surgical Wellness

What's New?

- The number of pain meds used continues to decrease
  - 3.5 pills
- Smoking and inguinal hernia
- Coding and billing
- Verified Surgeon of Quality
- New Platform & Data Abstractor
  - Hiatal Hernia Registry
- Special Interest: Plastic surgery - ACHQC data

3.5 pills consumed

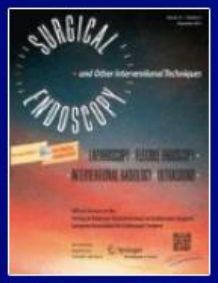
OPIOID

Characteristic	12 month % (%tile)	Quarterly	2023 Q2 % (%tile)	25th %tile	50th %tile	75th %tile
Ventral						
Median # of tablets prescribed	10 (56)		N/A	10	10	15
Median # of tablets consumed	3.5 (83)		N/A	1	2	8
Zero tablets consumed	18.2 (14)		N/A	18	33	50
		2022 Q3 2022 Q4 2023 Q1 2023 Q2				
Inguinal						
Median # of tablets prescribed	10 (77)		10 (71)	6	10	12
Median # of tablets consumed	3.5 (90)		0 (49)	0	1	4
Zero tablets consumed	28.6 (11)		100 (100)	33	50	82
		2022 Q3 2022 Q4 2023 Q1 2023 Q2				

The effect of smoking status on inguinal hernia repair outcomes: An ACHQC analysis

Published: 12 April 2023

Volume 37, pages 5464–5471, (2023) Cite this article

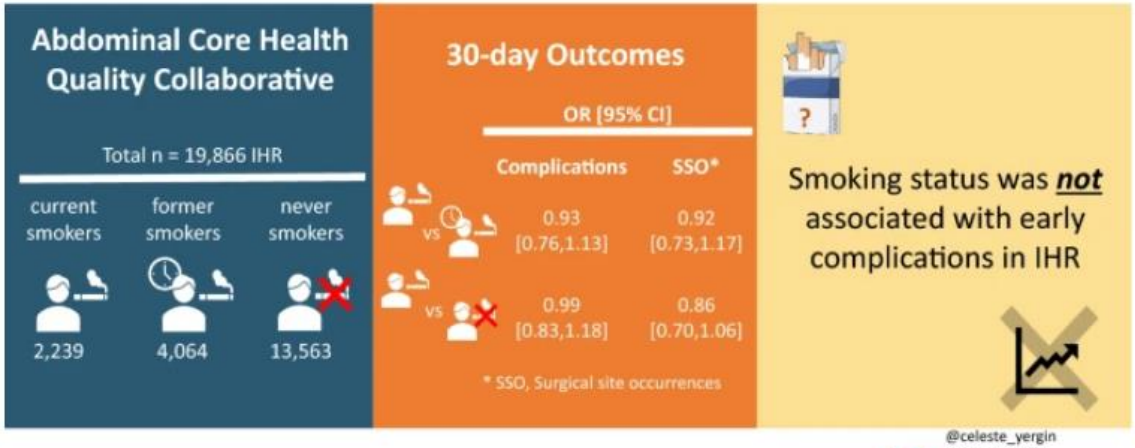


Surgical Endoscopy

Conclusions

Smoking status is not associated with short-term adverse outcomes following inguinal hernia repair. Mandating smoking cessation does not appear necessary to prevent short-term adverse outcomes.

Graphical abstract



Hernia (2022) 26:589–597
https://doi.org/10.1007/s10029-021-02458-w

ORIGINAL ARTICLE

A pragmatic, evidence-based approach to coding for abdominal wall reconstruction

Abdominal Core Health Quality Collaborative[1]

Received: 16 May 2021 / Accepted: 12 July 2021 / Published online: 30 October 2021

Abstract

Purpose Ambiguity exists defining abdominal wall reconstruction (AWR) and associated Current Procedural Terminology code usage in the context of ventral hernia repair (VHR), especially with recent adoption of laparoscopic and robotic-assisted AWR techniques. Current guidelines have not accounted for the spectrum of repair complexity and have relied on expert opinion. This study aimed to develop an evidence-based definition and coding algorithm for AWR based on myofascial releases performed.

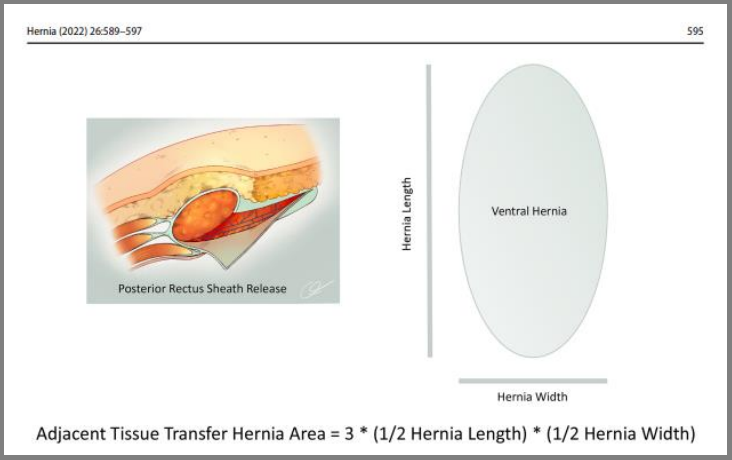
Methods Three vignettes and associated outcomes were evaluated in adult patients who underwent elecive VHR with mesh between 2013 and 2020 in the Abdominal Core Health Quality Collaborative including: (1) no myofascial release (NR), (2) posterior rectus sheath myofascial release (PRS), and (3) PRS with transversus abdominis release or external oblique release (PRS-TA/EO). The primary outcome measure was operative time based on the following categories (min): 0–59, 60–119, 120–179, 180–239, and 240 + ; secondary outcomes included disease severity measures and 30-day postoperative outcomes.

Results 15,246 patients were included: 7287(NR), 2425(PRS), and 5534(PRS-TA/EO). Operative time increased based on myofascial releases performed: 180–239 min ($p < 0.05$): NR(5%), PRS(23%), PRS-TA/EO(28%) and greater than 240 min ($p < 0.05$): NR (4%), PRS (17%), PRS-TA/EO(44%). A dose–response effect was observed for all secondary outcome measures indicative of three distinct levels of patient complexity and outcomes for each of the three vignettes.

Conclusion AWR is defined as VHR including myofascial release. Coding for AWR should reflect the actual effort used to manage these patients. We propose an evidence-based approach to AWR coding that focuses on myofascial release and is inclusive of minimally invasive techniques.

Keywords Ventral hernia · Abdominal wall reconstruction · Current procedural terminology · Coding · Billing

https://link.springer.com/article/10.1007/s10029-021-02458-w



EPIC SmartPhrase for Posterior rectus sheath myofascial release (PRS)

Technical expertise and operative time is required for posterior rectus sheath release to accomplished this surgery to bring complete closure to the midline ventral hernia. PRS is utilized utilization of adjacent tissue transfer code CPT 14301 (adjacent tissue transfer or rearrangement, any area, defect 30.1 square centimeters to 60.0 square centimeters) and if needed, CPT 14302 (each additional 30.0 square centimeters or part thereof) to represent the additional work performed when PRS is utilized (https://pubmed.ncbi.nlm.nih.gov/34718918/).

I incised in the posterior rectus sheath which then allows medialization of rectus complex to facilitate facial closure and ventral hernia repair. The total area involved in tissue transfer.
Formula used to calculate hernia area is 3 x (1/2 hernia length) x (1/2 hernia width).

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Verified Surgeon of Quality

The goal of the ACHQC Verified Surgeon of Quality program is to recognize and distinguish participating surgeons for their dedication to improving the quality and value of health care for patients who suffer from hernia disease and diseases of the abdominal wall or abdominal core. Improved quality and value are realized through the consistent entry of data in the ACHQC Registry and participation in ACHQC's continuous quality improvement programs.

ACHQC leadership believes surgeons focusing on quality improvement efforts will perform at their highest level. We hope that through this verification program, surgeons will be recognized by their peers and broader network for their dedication to improving the quality and value of patient care in their communities.

For questions about the ACHQC Verified Surgeon of Quality program, email aileen@achcq.org.

https://achqc.org/faqs/verified-surgeons-of-quality

ACHQC Verified Surgeon of Quality Spotlight

Hometown: Charlotte, NC

Training:

- Medical School - MUSC, Charleston, SC
- Residency - Greenville Hospital System, Greenville, SC
- MIS Fellowship - Charlotte, NC

How long have you been a member of the QC?

- Since inception!

Favorite part about the QC?

- QI Summit, meeting colleagues, and improving patient outcomes

Hobbies:

- Sports, skiing, travel

William Hope, MD
New Hanover Regional Medical Center
Wilmington, NC

ACHQC Verified Surgeons of Quality

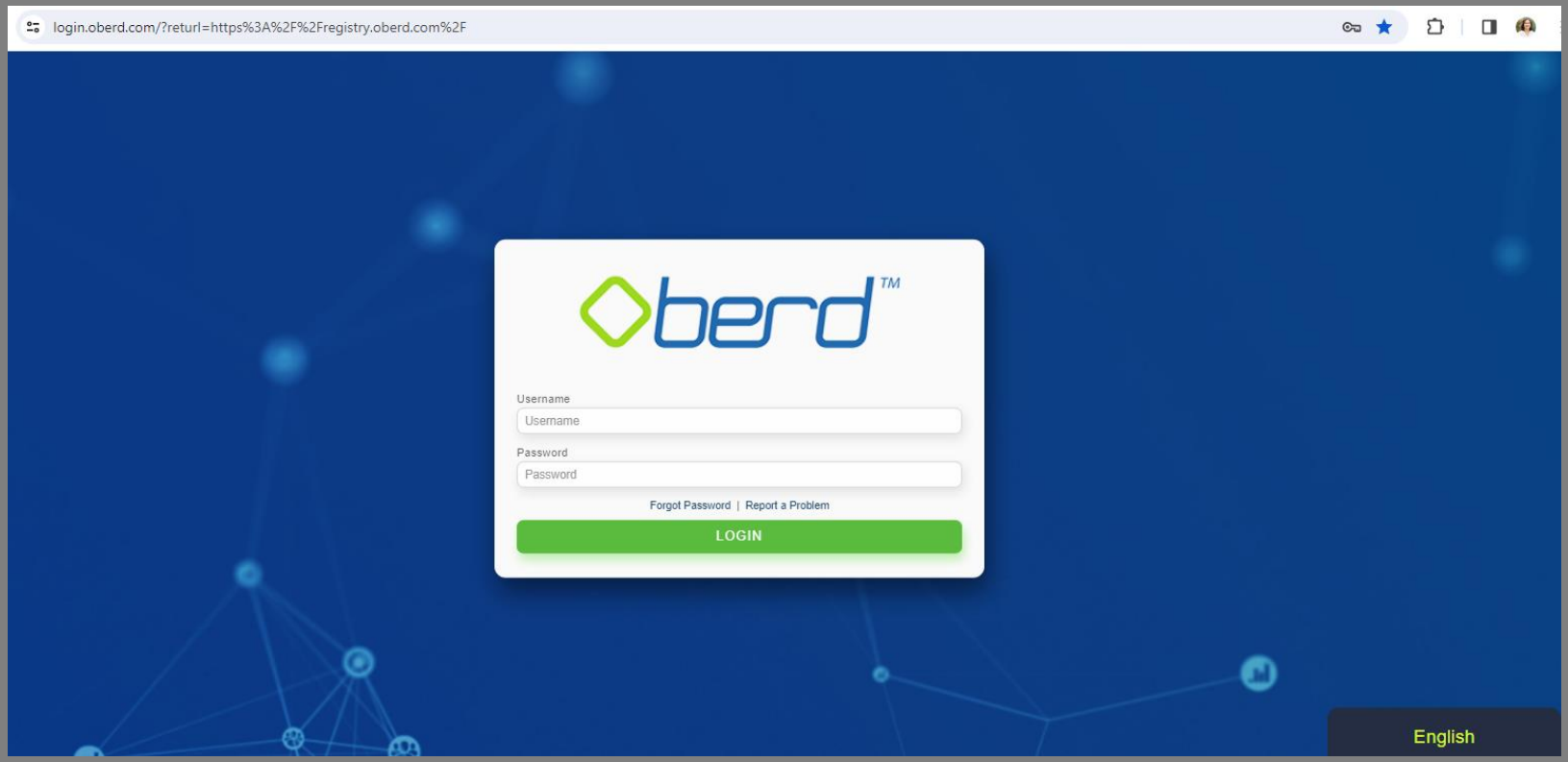
CHRISTOPHER BAILEY, MD

Austin Regional Clinic - Austin, TX

As an extremely physically active person, facilitating early return to work and getting people back to 100% is my biggest priority. For this reason, I am most passionate about advancing my own practice and teaching other surgeons minimally invasive hernia repair techniques with the robotic platform. Being a part of the ACHQC since its inception has been a critical part of this mission worldwide.

LUCAS BEFFA, MD

https://www.oberd.com/achqc/

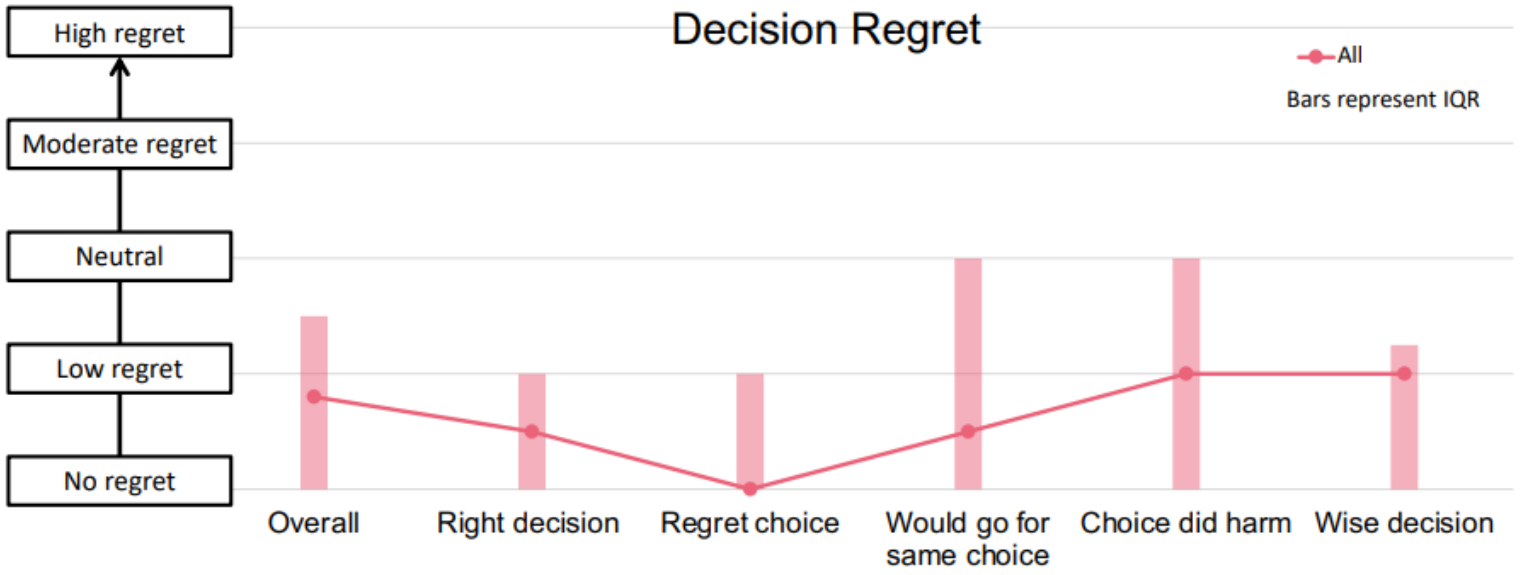


Knowledge gained from Quality Improvement Summit

Long-term Outcomes, Patient Reported Assessment, and Decision Regret of TRAM/DIEP Hernia Repairs

Katherine C. Montelione MD MS
Caroline McLaughlin MD
Michael J. Rosen MD FACS
Ajita S. Prabhu MD FACS
David M. Krpata MD FACS
Clayton C. Petro MD
Steven Rosenblatt MD
Eric Pauli MD
Lucas R Beffa MD
Chao Tu MS
Charlotte Horne MD

Patients had high regret for breast reconstruction (and sequelae), but low regret for hernia repair



Thank You

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