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SEE YOU NEXT TIME!

ANNUAL LEADERSHIP
CONFERENCE
NOVEMBER 4-6, 2019 • PHOENIX

QUALITY & SAFETY
IN CHILDREN’S HEALTH CONFERENCE
MARCH 9–11, 2020 • KANSAS CITY

childrenshospitals.org/quality19  #Quality19
Wireless Instructions
1. Turn wireless access on
2. View available wireless networks
3. Select CHAQSC2019 and connect
4. Open your web browser; you will be directed to the login page
5. Access code: Champions4Kids
6. Your page will default to the hotel website
7. You can now access any website

If you have difficulties with the wireless connection, please stop by the Registration Desk on the second floor.

Social Media
Be a part of the conference action. Follow, share and comment on social media.

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REGISTRATION HOURS
Registration Desk, 2nd Floor

Sunday, March 17 3 – 5:30 p.m.
Monday, March 18 7 a.m. – 7:30 p.m.
Tuesday, March 19 7 a.m. – 5 p.m.
Wednesday, March 20 7 a.m. – 5 p.m.
Thursday, March 21 7 a.m. – 4:30 p.m.
Friday, March 22 7 a.m. – 12 p.m.

POSTER PRESENTATION HOURS
The Link – Galleria Level

Browse posters beginning Monday at 6:30 p.m. through Wednesday at 12:30 p.m. in The Link, located on the Galleria Level. Poster presenters will be available to answer questions during the days and times below.

Meet the Poster Presenters
Monday, March 18 6:30 – 7:30 p.m.
Tuesday, March 19 1:45 – 2:15 p.m.
Wednesday, March 20 7:15 – 7:45 a.m.

CONFERENCE MOBILE APP
CHA members can access the conference mobile app. Search “Children’s Hospital Association” in the Apple or Android store. Once downloaded, log in to the app with the password Quality19. The app includes session descriptions, poster information, and more.
We would like to thank the committee members for volunteering their time and expertise to help us develop an outstanding conference experience for children's hospital professionals.

**Member Advisory Committee**

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Associate Chief Medical Officer
Ann & Robert H. Lurie Children's Hospital of Chicago

LesleyAnn Carlson, M.S.N., RN, NE-BC, CPN
Associate Chief Nursing Officer
Rady Children’s Hospital San Diego

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Riley Hospital for Children at Indiana University Health

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Levine Children’s Hospital

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Emily Tooley
Analyst, Patient Safety

Monique Trojacek
Director, Education
MEMBER RESOURCES

Visit the conference website for valuable information
www.childrenshospitals.org/quality19

Consent to Use of Photographic Images
Conference registration, attendance or participation constitute an agreement by the registrant to allow CHA use and distribution (both now and in the future) of the attendee’s image or voice in photographs, videotapes, electronic reproductions and audiotapes of conference events and activities.

Tell Us What You Think: Conference Evaluations
Attendees receive an online survey to evaluate sessions at the end of each day, as well as an overall survey following the conference. Participation in these evaluations is required to receive continuing education credits.

Posters and Sessions Eligible for CME and/or CNE
The conference features posters and sessions eligible for continuing education credit.
Look for this symbol: 1.0 CME/CNE

Power Sessions
The conference features several “power sessions” that connect two or more hospitals in one session to explore multiple perspectives on a topic
Look for this symbol:

IMPACT Sessions
These sessions were developed for pediatric health care experts from all quality, safety and clinical disciplines and are open to all conference and affinity group participants.
Look for this symbol:

Conference Learning Outcomes
Upon completion of this educational activity, participants will be able to:

- Describe best practices to improve care delivery systems, care coordination and outcomes in managing the health care of children.
- Discuss unique approaches to improving the patient experience through advances in patient and family engagement.
- Explore innovative strategies to build clinical effectiveness and impact safety in health care.
- Share key strategies within their health care teams that can be used to improve quality and safety outcomes.

For poster and session-specific objectives, please visit childrenshospitals.org/quality19.
MEMBER RESOURCES

Continuing Education
As an accredited provider of continuing education (CE), Children’s Hospital Association has a conflict of interest policy that requires everyone in a position to control the content of an education activity to disclose all relevant financial relationships with any commercial interest. Any potential conflicts are resolved so that presentations are evidenced-based and scientifically balanced. No conflict of interest exists for any CE presenter/author or planning committee member related to the content of this educational activity.

In support of improving patient care, Children’s Hospital Association is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the health care team.

For Physicians: Children’s Hospital Association designates this live activity for a maximum of 8.00 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For Nurses: Children’s Hospital Association designates this activity for a maximum of 10.00 ANCC contact hours.

Criteria for successful completion of this educational activity includes confirmation of individual poster(s) or session(s) attendance in its entirety and completion of program evaluation. A link to the online combined program Evaluation and Verification of Attendance survey will be emailed to participants. To receive a certificate of completion, attendees must complete the survey. Certificates will be emailed to participants.

ACHE Qualified Education
Children’s Hospital Association is authorized to award up to 12.75 contact hours of pre-approved ACHE Qualified Education credit for this program toward advancement, or recertification, in the American College of Healthcare Executives. Participants in this program who wish to have the continuing education hours applied toward ACHE Qualified Education credit must self-report their participation. To self-report, participants must log into their MyACHE account and select ACHE Qualified Education Credit.

Verification of Attendance
By attending the conference, you have the opportunity to earn credit that may satisfy your continuing education requirements. Complete the online verification form only once after attending the conference. Certificates will be emailed to participants.
MONDAY, MARCH 18

5 – 6:15 p.m. KEYNOTE SESSION with Danielle Ofri, M.D., Ph.D. Grand Salon
6:15 – 8 p.m. Networking Reception The Link-Galleria Level

TUESDAY, MARCH 19

7 – 8 a.m. Breakfast The Link-Galleria Level

8 – 9 a.m. EDUCATION SESSIONS
☐ Power Session: Demonstrating ROI Through Quality Advancements Grand Ballroom B
☐ Power Session: Improving Patient and Family Partnerships Galleria 5
☐ Power Session: Tackling the Opioid Crisis Grand Ballroom A
  This session will be recorded
☐ Power Session: Using Lean to Improve Access Grand Ballroom C
☐ Systematically Improving Quality within a Pediatric Clinically Integrated Network Grand Ballroom D

9:15 – 10 a.m. EDUCATION SESSIONS Sessions repeat 10:15-11 a.m.
☐ Building Better Access and Retention in Behavioral Health Grand Ballroom A
  This session will be recorded
☐ Discovering Latent Safety Threats in Pediatric Post-Construction Health Care Design Grand Ballroom B
☐ Improving Access and Value Through eConsults and Project CORE Grand Ballroom C
☐ Little People in a Big World: Assuring Quality Pediatric Care in Any Health System Galleria 5
☐ Special Needs Tracking and Awareness Response System Grand Ballroom D

10:15 – 11 a.m. EDUCATION SESSIONS Repeat of 9:15-10 a.m. sessions
☐ Building Better Access and Retention in Behavioral Health Grand Ballroom A
  This session will be recorded
☐ Discovering Latent Safety Threats in Pediatric Post-Construction Health Care Design Grand Ballroom B
☐ Improving Access and Value Through eConsults and Project CORE Grand Ballroom C
☐ Little People in a Big World: Assuring Quality Pediatric Care in Any Health System Galleria 5
☐ Special Needs Tracking and Awareness Response System Grand Ballroom D

11:15 – 11:45 a.m. EDUCATION SESSIONS
☐ Blending Care of the Pediatric Body and Mind Grand Ballroom B
☐ Improving Medication Use Through Preemptive Pharmacogenomics Grand Ballroom C
☐ Medical Home Care Management for Children with Medical Complexity Grand Ballroom D
☐ Rescue Me: Challenges and Solutions to PEWS and RRT Implementation Grand Ballroom A
  This session will be recorded

11:45 a.m. – 1 p.m. Networking Luncheon with Table Topic Discussions The Link-Galleria Level

1:15 – 1:45 p.m. EDUCATION SESSIONS
☐ Addressing Safety Issues with a Comprehensive Workplace Violence Prevention Program Grand Ballroom B
☐ Building an Effective Patient Transition of Care System Grand Ballroom A
  This session will be recorded
☐ Pediatric Support Services: A Care Coordination “Easy Button” Grand Ballroom C
☐ Quality 3.0: Improving Across All Domains of Quality Galleria 5
☐ Transforming Neonatal Intensive Care: Caring for Mom and Baby Together Grand Ballroom D
1:45 – 2:15 p.m.  Dessert Reception and Meet Poster Presenters  The Link–Galleria Level

2:15 – 2:45 p.m.  **EDUCATION SESSIONS**
- Increasing Resident Physician Engagement in Safety Through Event Reporting  Grand Ballroom B
- Quality 3.0: A Culture of Standardization to Evolve Quality Beyond Safety  Grand Ballroom C
- Target-Based Care: Leveraging EHR-Derived Benchmarks to Reduce Postoperative LOS  Grand Ballroom A
  - This session will be recorded
- The Harm Index: Capturing the Big Picture of Harm Prevention  Grand Ballroom D

3 – 4:30 p.m.  **KEYNOTE SESSION with Ingrid Fetell Lee**  Grand Salon
4:30 – 6 p.m.  Networking Reception  The Link–Galleria Level

**WEDNESDAY, MARCH 20**

7 – 8 a.m.  Breakfast  The Link–Galleria Level

8 – 9 a.m.  **EDUCATION SESSIONS**
- Power Session: Advancing Root Cause Analysis  Grand Ballroom A
- Power Session: Affecting Patient Safety Through Infection Control  Grand Ballroom B
- Power Session: Implementing Change to Improve Care  Grand Ballroom C
- Power Session: Integrating Clinical Effectiveness Teams  Grand Ballroom D
- Quality 3.0: Patient Experience as an Organizing Principle for Driving Quality  Galleria 5

9:15 – 10 a.m.  **EDUCATION SESSIONS**
- A Guide to Quality Improvement for High-Volume Pediatric Subspecialty Practices  Grand Ballroom A
- Hospitalist Run Discharge Clinics: A Three-Year Retrospective  Grand Ballroom B
- Improving Outcomes for Behavioral Disorder Patients Using Coping Plans  Grand Ballroom C
- Leveraging the Electronic Medical Record to Improve Sepsis Mortality Rates  Grand Ballroom D

10:15 – 11 a.m.  **EDUCATION SESSIONS**
- BEE MINDFUL: A Sweet Approach for Children with Special Needs  Grand Ballroom A
- Building a Medical Neighborhood: Integrating Outpatient Clinics  Grand Ballroom B
- Care Integration is Essential to Achieving High Value  Grand Ballroom C
- Clinical Impacts of the Improving Pediatric Sepsis Outcomes Collaborative  Galleria 5
- Partnerships Serving Families of Children with Severe Behaviors  Grand Ballroom D

11 a.m. – 12:30 p.m.  Networking Luncheon  The Link–Galleria Level

12:30 – 1:15 p.m.  **IMPACT SESSIONS**
- After Hurricane Maria: Managing Evaporation of the Intravenous Fluid Supply  Grand Ballroom A
- How a Mother’s Story and Sharing Across Hospitals has Transformed Pediatric Safety  Grand Ballroom D

1:30 – 2:15 p.m.  **IMPACT SESSIONS**
- Learning Collaboratives for Quality Improvement Initiatives in Pediatric Hospital Expansions  Grand Ballroom A
- Using Clinical Redesign to Enhance Quality and Drive Cost Reduction  Grand Ballroom D
Learn more about the unique projects taking place in children’s hospitals. Visit with poster presenters during the networking times on Monday, Tuesday and Wednesday. For poster descriptions and objectives, visit children’s hospitals.org/quality19

Meet with five poster authors and get five stamps to receive a CHA notebook. Present your learning guide with the five stamps at the conference registration desk to get your notebook.

1. **Pediatric Sepsis Recognition in Community Emergency Rooms**
   Emily Dawson, M.D., Medical Director, Performance Improvement
   Advocate Children’s Hospital | Oak Lawn, Illinois

2. **Proceed Until Apprehended: A Cultural Transformation**
   Lisa Labat, RN, Senior Director, Acute Care Services
   Jennifer Schwehm, RN, B.S.N., M.S.N., Director, Patient Safety & Quality
   Children’s Hospital | New Orleans

3. **“Beyond the Bundle” Using Data and Technology to Reduce CAUTI**
   Katherine Nowacki, M.P.H., CPHQ, Process Improvement Lead, Patient Safety
   Children’s Hospital Colorado

4. **Reliable Hazard Reduction in MRI**
   Darwin Roth, RN, B.S.N., CPN, Patient Safety Specialist
   Children’s Hospital Colorado

5. **Sepsis e-Learning Curriculum: Leveraging “Confidently Held Misinformation” and “Learner Struggle”**
   Justin Lockwood, M.D., MSCS, Pediatric Hospitalist
   Children’s Hospital Colorado
   Amber R. Phipps, MBA, DBA, Vice President, Quality and Patient Safety
   Children’s Hospital & Medical Center | Omaha, Nebraska

7. Minimizing Occlusion Alarms Following Implementation of Filter Tubing for Lipids
   Amy Gisslen, Pharm.D., Medication Safety Pharmacist
   Jessica Zeirke, LSSBB, Quality and Patient Safety Consultant
   Children’s Hospitals and Clinics of Minnesota

8. Multidisciplinary Quality Improvement Education Across a Pediatric Primary Care Network
   David Cruz, M.H.S.A., CPHQ, Clinical Operations Portfolio Manager
   Elena Huang, M.D., Director of Quality for Primary Care,
   Continuity Clinic Director
   Children’s Hospital of Philadelphia

9. Gastric Feeding on HFNC in Pediatric Critical Care Units
   Sameer Kamath, M.D., MBBS, Medical Director, PICU
   Duke Children’s Hospital & Health Center | Durham, North Carolina

10. Resident-Driven Safety Initiatives
    Annalicia Burns, M.D., PGY1
    Duke Children’s Hospital & Health Center | Durham, North Carolina

11. Low Volume High Risk Preventing Vitamin K Refusal
    Michael Weiss, Assistant Director, Pediatric Emergency Medicine
    Physician Informatics
    Joe DiMaggio Children’s Hospital at Memorial Regional Hospital
    Hollywood, Florida
12. Managing Methadone Weaning Protocol and Withdrawal Assessment  
Ryan Walters, Pharm.D., BCPS, Pharmacy Clinical Specialist  
Joe DiMaggio Children’s Hospital at Memorial Regional Hospital  
Hollywood, Florida

13. Outpatient Bronchiolitis Clinic Reduces Readmissions and Resource Use  
Pamela Elder, RRT, B.S., AE-C, Respiratory Therapist  
Joe DiMaggio Children’s Hospital at Memorial Regional Hospital  
Hollywood, Florida

14. Achieving High Reliability in Preventable Harm  
Julie Reynolds, B.S.N., M.P.H., CPHQ, Manager, Patient Safety and Quality  
Johns Hopkins All Children’s Hospital | St. Petersburg, Florida

15. Promote Fertility Preservation in Children Facing Chemotherapy  
Adriana M. Delgado, CCRP, Certified Clinical Research Coordinator  
Mayo Clinic Children’s Center | Rochester, Minnesota

16. Febrile Neonates: Treating Small Patients with Big Risks  
Chelsea Carter, B.S.N., RN, CCRN, CPEN, AEMT, Quality Improvement Analyst  
Monroe Carell Jr. Children’s Hospital at Vanderbilt | Nashville, Tennessee

17. Initiation of Multi-Disciplinary, Family-Centered Rounds in Pediatric Hematology/Oncology  
Kelly Kelleher, M.D., Staff Physician  
Phoenix Children’s Hospital

18. Quality Assessment of Instrument-Based Preschool Vision Screening  
John Hanks, M.D., Pediatrician  
Katherine Lee, M.D., Ph.D., Pediatric Ophthalmologist  
St. Luke’s Children’s Hospital St. Luke’s Regional Medical Center | Boise, Idaho
19. **Move from the Bottom Percentile to Top 50 Ranking**  
Jennifer Ball, M.P.H., Quality Coordinator  
Richard W. Brant, M.D., Medical Director, Quality and Patient Safety  
West Virginia University Children’s Hospital | Morgantown, West Virginia

20. **Sustaining a Culture of Safety Through Recognition and Celebration**  
Lauren Edwards, B.S.N., RN, Performance Improvement Coordinator  
Yale New Haven Children’s Hospital | Connecticut

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**POSTER PRESENTATIONS**

- **THE LINK!**  
  Located on Galleria Level  
  Enjoy the space designated for networking and casual learning

- Ask questions at the Member Resource Center
- Grab refreshments
- Chance to receive a complimentary photo exhibit stop at your hospital
- Interactive experience: Find value with a ping pong ball
- Poster presentations
- Relax or work. Take advantage of breaks the way you need
KEYNOTE SESSION
Danielle Ofri, M.D., Ph.D.
Grand Salon

What Patients Say, What Doctors Hear (and Vice Versa): The Highest Stakes in Medicine
The Power of Words: Despite modern medicine’s infatuation with high-tech gadgetry, the single most powerful diagnostic tool is the doctor-patient conversation. However, what patients say and what doctors hear are often two different things. Patients feel an urgency to make their case. Doctors multitask while patients speak. Stereotypes, unconscious bias, conflicting agendas and fear of lawsuits multiplies the risk of misdiagnosis and medical errors. Ofri will examine whether refocusing the caregiver-patient conversation can lead to better health outcomes.

About Danielle Ofri
Ofri writes regularly for The New York Times about medicine and the critical connection between doctor and patient. Her newest book, What Patients Say; What Doctors Hear explores how refocusing the conversations between doctors and patients can lead to improved health outcomes. In her book, What Doctors Feel: How Emotions Affect the Practice of Medicine, Ofri upends stereotypes and explores the hidden emotional world of the doctor and its impact on patient care. As a practicing internist at Bellevue Hospital—Ofri speaks with the authenticity of a physician directly engaged in the front lines of medical care. She confronts the major medical issues of our time on a daily basis without losing focus on the patient.
TUESDAY MORNING

7 - 8 a.m.
Breakfast
Galleria Level

8 - 9 a.m.

EDUCATION SESSIONS

**POWER SESSION**

1.0 CME/CNE  
*Demonstrating ROI Through Quality Advancements*  
Grand Ballroom B

Children’s Hospital of Richmond at VCU and Children’s Healthcare of Atlanta share how simple tools and the Safety Coach Program can enhance quality.

**Demonstrating the Value of Your Quality Work to Your Organization**

In Children’s Hospital of Richmond at VCU’s pediatric hematology/oncology division, staff created a portfolio of small quality improvement projects. They supported multiple projects that affect a diverse group including sickle cell, benign hematology and cancer patients. The hospital used a variety of tools to show project value including calculating the number needed to prevent admission or harm; costs savings from more efficient care and increased bed capacity via decreased length of stay; reduction in adverse events; and improving care coordination to decrease emergency department and inpatient utilization.

**Jeniece S. Roane, M.S., RN, NE-BC**
AVP Clinical Operations and ACNO Women’s and Children’s Health

**Matthew Schefft, D.O., M.S.H.A.**
Assistant Professor of Pediatrics, Hem/Onc Quality Lead  
Children’s Hospital of Richmond at VCU | Richmond, Virginia

**Safety Coach: Constructing a Culture of Safety to Advance Quality**

Children’s Healthcare of Atlanta’s quality journey escalated with a serious safety event that had a devastating effect on the family, nurse and team of caregivers. It heightened the hospital’s challenged journey to eliminate preventable patient harm. They started the Safety Coach Program to sustain the passion to decrease the incidence of human error by consistent use of error prevention skills, elimination of hospital-acquired conditions through bundle elements and supporting the emotional health of employees through a Just Culture.

**Traycee Newton, RN**
Program Manager

**Renee Watson, RNC, B.S.N., CPHQ, CIC**
Senior Director, Quality and Patient Safety  
Children’s Healthcare of Atlanta
Improving Patient and Family Partnerships
Galleria 5

Children’s Health, Dallas and Kaiser Foundation Hospital – Roseville, Women’s and Children’s Services describe how the Family Advisor Network partnership and CoDesign drive meaningful improvements in the patient care experience.

Become a FAN: An Innovative Approach to Offering Family Partnerships
Over the last five years, Children’s Health, Dallas struggled to find the best approach to sustaining meaningful partnerships with families that added value to the system as a whole. With a greater emphasis on consumerism, the organization wanted a more cohesive program that aligned with the health care system’s strategic priorities, so they created the Family Advisor Network (FAN). By moving away from only offering the traditional structure of the singular family advisory councils, the FAN better meets system needs through seven partnership opportunities that target the system’s strategies: quality, growth, people and efficiency.

Brennan Lewis, M.S.N., RN, CPNP, PCNS
Director, Patient Education & Engagement
Children’s Health, Dallas

Partnering with Patients and Families as Equals to Transform Care
Patient care experience scores at Kaiser Foundation Hospital – Roseville, Women’s and Children’s Services needed to improve, so when staff designed a value stream analysis to help make improvements, they decided to use a new approach called CoDesign. The CoDesign process committed the organization to incorporating patients’ voices. Working together, they identified bright spots and areas of opportunities that were important to the patients and families. The hospital implemented an immediate change based on this collaboration and have seen a positive trend in patient experience scores.

Krystle Banfield, M.S, RN, CCRN
Assistant Nurse Manager
Kaiser Foundation Hospital – Roseville, Women’s and Children’s Services

Zoey Goore, M.D., M.P.H., FAAP
Physician Lead, Pediatric Quality and Safety

Amanda Smith, RN, CCRN
Assistant Nurse Manager
Kaiser Foundation Hospital – Roseville, Women’s and Children’s Services
Roseville, California
Harnessing the EHR to Reduce Unnecessary Opioid Exposure in Children
Recent data highlights morbidity and adverse outcomes from pediatric opioid exposure and the contributory role of clinicians and their prescribing of opioids to the development of opioid misuse in adolescence and adulthood. Rady Children’s Hospital San Diego examined opioid prescription practices at their institution and found room for improvement. Staff launched an electronic health record intervention targeting outpatient opioid prescriptions and have demonstrated notable improvements in reducing amount and duration of opioid prescriptions in both medical and surgical subspecialties.

Erin Dale, M.S.N., RN, FNP-C
Acute Pain Nurse Practitioner

Jeannie Huang, M.D., M.P.H.
Director, Clinical Medical Education
Rady Children’s Hospital San Diego

Stop at Seven: Reducing Unintended Variation in Discharge Opioid Prescribing
Prescribing practices are a key driver of the opioid epidemic in the U.S., and there is a paucity of research to guide pediatric prescribing. Children’s Hospital Colorado developed a new clinical pathway to reduce unnecessary variation in opioid prescribing. The team designed a measurement system, queried baseline data, conducted chart reviews, and garnered local expert consensus to inform a recommendation to limit discharge opioid prescriptions to a seven day supply for hospitalized non-cancer, non-ICU patients with acute pain. Subsequently, the team partnered with orthopedic surgery to design and test interventions to increase compliance with the discharge prescribing recommendations.

Leigh Anne Bakel, M.D.
Assistant Professor of Pediatrics and Pediatric Hospital Medicine

Sarah Nickels, M.D.
Process Improvement Lead
Children’s Hospital Colorado
Addressing Central Registration Bottlenecks with Lean Six Sigma

With the current system and processes, it was taking more than 20 minutes on average for patients to register and check in before their scheduled appointment time at Arkansas Children’s Northwest. This caused patients and providers dissatisfaction and negatively impacted waiting times for patients and staff members. Detailed patient visit time data analysis indicated a bottleneck at the centralized registration. It was a crucial initiative for the newly opened hospital which is the only pediatric health care facility in the region to satisfy the needs of that community.

Dominique S. Harris, MBA
Manager of Admissions, Financial Counseling

Abdullah Rajoub
Process Improvement Engineer
Arkansas Children’s Hospital

Scan Sooner: Applying Six Sigma Methodology to Improve MRI Access

Excessive wait times for magnetic resonance imaging (MRI) scans create unnecessary delays in medical care and undue stress on patients and families awaiting an appointment. Prior to this improvement project, wait times averaged nine to 10 weeks for patients requiring sedated studies. A multidisciplinary project team of physicians, clinical staff, and process improvement experts at Arkansas Children’s Hospital used Six Sigma methods to develop and implement interventions to improve MRI access. Staff conducted a time study to identify key opportunities for improvement within scheduling and operations practices to achieve the project goal. In addition to better patient access, patient and referring provider satisfaction increased.

Justin Criddle, CSSBB
Senior Process Improvement Engineer
Arkansas Children’s Hospital
Systematically Improving Quality within a Pediatric Clinically Integrated Network
Grand Ballroom D

Clinically integrated networks are forming in response to a national shift in how health care is being financed and delivered – from a fee-for-service model that promotes volume of services to a value-based model that promotes keeping children healthy. Children’s Mercy Kansas City’s clinically integrated network developed a common operational framework to improve and sustain quality performance across 12 pediatric measures. The network achieved increases of 4 to 51 percentage points using a strong governance structure, adherence to the network’s guiding principles, transparent reporting, and a systematic process to identify, share, and disseminate best practices. A detailed application of the framework will demonstrate how the network improved HPV vaccination performance from below the national 50th percentile performance to above the national 90th percentile performance in two years.

Luke Harris, MBA
Director, Operations & Population Health Management
Children’s Mercy Kansas City

9:15 – 10 a.m.

So that you can benefit from as many presentations as possible, these sessions repeat in the 10:15 – 11 a.m. time period.

EDUCATION SESSIONS

Building Better Access and Retention in Behavioral Health
Grand Ballroom A

Nationwide Children’s Hospital developed three key interventions within the behavioral health service line to build capacity to meet the growing need of behavioral health services: implementation of Just-in-Time (JIT) scheduling, reducing staff turnover and expanding the nursing scope. JIT scheduling increased the volume of scheduled referrals and helped reduce no-show rates. Expansion of the psychiatric mental health nursing role in assessments and care coordination helped support providers in managing high patient volume. The organization is evaluating a new preceptorship model to improve job satisfaction and reduce turnover to preserve experienced staff.

Joshua R. Ebling, MSW, LISW-S
Director, Outpatient Services, Behavioral Health and Practice Plan Administrator, Psychiatry

Jahnavi Valeru, M.S.
Manager, Quality Improvement Services
Nationwide Children’s Hospital | Columbus, Ohio
Discovering Latent Safety Threats in Pediatric Post-Construction Health Care Design
Grand Ballroom B

Children’s Healthcare of Atlanta recently opened a state-of-the-art, outpatient subspecialty center which underwent a four-phase opening. The hospital integrated simulation in a post-construction environment to test how the overall design affects patient safety, workflow and processes. Latent safety threats are inevitable in the design of new health care facilities. Design teams lack the clinical lens, framework and ability to address patient safety threats in the design process. The hospital created simulations because no standard process existed to aid health care organizations in implementing a simulation-based clinical testing program to assess the safety of new health care facilities.

Nora Colman, M.D.
Pediatric Intensivist

Kiran Hebbar, M.D.
Medical Director; Simulation Center, Pediatric Intensive Care
Children’s Healthcare of Atlanta

Improving Access and Value Through eConsults and Project CORE
Grand Ballroom C

Specialist workforce shortages and rising demands for referrals from primary care providers (PCPs) have led to severe access challenges for many children’s hospitals. Children’s Hospital at Dartmouth-Hitchcock is one of eight children’s hospitals implementing CORE for Kids, the pediatric arm of Project CORE (Coordinating Optimal Referral Experiences). The program aims to improve quality and efficiency of care at the interface of primary care and specialty care in the ambulatory setting. At the heart of CORE are eConsults and enhanced referrals, EMR-based tools implemented by the participating institutions that improve effective communication and coordination between PCPs and specialists, delivering on the Quadruple Aim.

Robert Rohloff, M.D.
Physical Lead, Quality and Patient Safety

Erik Shessler, M.D.
Vice Chair, Community Pediatrics

Scott Shipman, M.D., M.P.H.
Director, Clinical Innovations
Children’s Hospital at Dartmouth-Hitchcock | Lebanon, New Hampshire
Little People in a Big World: Assuring Quality Pediatric Care in Any Health System

Galleria 5

Many children are cared for in non-pediatric specific facilities by nurses who primarily care for adult patients. The majority of these facilities care for low volumes of pediatric patients (<1800 a year) and have a National Readiness Score of only 62 percent. Cohen Children's Medical Center created a pediatric service-line model with a quality dashboard, education and spread of standardized care bundles. In 2017, the hospital increased care delivered to children outside the walls of the children's hospital by 40 percent from the previous two years. Following use of the new model, the number of reported falls, adverse drug events and hospital-acquired conditions were among several quality indicators that improved.

Sharon Goodman, M.A., RN-BC, CPNP
Assistant Director, Nursing

Jennifer Simonetti, M.S.N., RN, CPN
Assistant Director, Nursing
Cohen Children’s Medical Center | New Hyde Park, New York

Special Needs Tracking and Awareness Response System

Grand Ballroom D

Special needs Tracking and Awareness Response System (STARS) was developed to interface with community emergency medical service (EMS) and hospitals. SSM Health Cardinal Glennon Children’s Hospital initiated individualized emergency care plans (ECP) for complex medical patients and each child is assigned a unique number linked to local 911 dispatch. ECPs include diagnoses, past procedures, medications, allergies, baseline physical exam, anticipated emergencies, procedures to be avoided and the preferred tertiary hospital. The ECP is maintained in the child’s home, with 911 dispatch and local EMS. Local air medical services are involved in rural settings. A STARS outreach team provides education seminars to local teams as complex medical patients are identified in their jurisdictions.

Patricia Casey, Paramedic
STARS Program Coordinator
SSM Health Cardinal Glennon Children’s Hospital | St. Louis
TUESDAY MORNING

10:15 – 11 a.m.

EDUCATION SESSIONS

Another chance to learn from proven processes, attend encore presentations from the 9:15 – 10 a.m. time period, including:

- Building Better Access and Retention in Behavioral Health Grand Ballroom A
- Discovering Latent Safety Threats in Pediatric Post-Construction Health Care Design Grand Ballroom B
- Improving Access and Value Through eConsults and Project CORE Grand Ballroom C
- Little People in a Big World: Assuring Quality Pediatric Care in Any Health System Galleria 5
- Special Needs Tracking and Awareness Response System Grand Ballroom D

See pages 17-19 for session descriptions.

11:15 – 11:45 a.m.

EDUCATION SESSIONS

Blending Care of the Pediatric Body and Mind Grand Ballroom B

In May of 2018, Dell Children’s Medical Center of Central Texas opened its first embedded pediatric mental health unit within its tertiary hospital and launched a 24/7 triage line for families and patients to self-refer. The hospital committed to finding a solution for the disjointed continuum of mental health care. The clinical care model included an integrated practice of existing hospitalist and transplanting pediatric mental health providers. The hospital continues to merge best practices in mental health care with existing acute care policies and procedures; finding the balance between a traditional care model and mental health milieu therapy.

Brandy Hart, M.S., LPC-S
Chief Administrative Officer

Liz Stacy, MBA
Project Analyst
Dell Children’s Medical Center of Central Texas | Austin
TUESDAY MORNING

Improving Medication Use Through Preemptive Pharmacogenomics
Grand Ballroom C

St. Jude Children’s Research Hospital supports the implementation of pharmacogenomics as a patient safety strategy in two primary ways. Locally, implementing preemptive pharmacogenomics through PG4KDS. In this effort, patients are offered pharmacogenomics testing early in their care and genes and medications are systematically added to their medical record over time. Thousands of patients have been genotyped through PG4KDS and genetic information from nine genes are used to guide prescribing of 23 different drugs. On a broader level, the hospital (with Stanford University) leads the National Institutes for Health funded Clinical Pharmacogenomics Implementation Consortium (CPIC). CPIC has produced 20 clinical practice guidelines that are widely used in pediatric and other settings.

James Hoffman, Pharm.D., M.S., BCPS
Chief Patient Safety Officer, ALSAC
St. Jude Children’s Research Hospital | Memphis, Tennessee

Medical Home Care Management for Children with Medical Complexity
Grand Ballroom D

Children’s Hospital of Philadelphia serves a medically and socially complex patient population in a patient-centered medical home. The multidisciplinary care management team for this group includes nurse care managers, physicians, community health workers, a social worker, and administrative support. The hospital implemented a quality improvement approach to provide: telephone follow-up within two days of unplanned hospital discharge and within three days of unplanned emergency department discharge, proactive well-visit scheduling and proactive influenza vaccine scheduling. Data reports provide identification of patients needing outreach. Performance was determined by comparing health care utilization during pre and post-enrollment periods.

Joan Dougherty, B.S.N., RN
Lead Care Manager, K2C Care Management Program

Emily Gregory, M.D., M.H.S.
Attending Physician & Medical Director, K2C Care Management Pilot

Sara Kurlansik, MSW, LSW
Social Worker, K2C Care Management Program
Children’s Hospital of Philadelphia
Children's Hospital of Richmond at VCU started a rapid response team (RRT) to facilitate rescue of a deteriorating child, permit rapid escalation of care and prevent cardiac arrests outside the PICU. The hospital added Pediatric Early Warning Score (PEWS) to improve recognition of children in need of RRT and escalation. Sequential Plan-Do-Study-Act cycles, adding a dedicated nursing PEWS band in the emergency medical record, a real-time alert of high PEWS, active monitoring to report missed RRT and escalation opportunities allowed for analysis and prompt feedback.

Jill McGehee, M.S., RN, CCRN-K  
PICU Nurse Clinician

Jose L. Munoz, M.D.  
Professor of Pediatrics  
Children's Hospital of Richmond at VCU | Richmond, Virginia

NEW Table Topics  
Networking with colleagues is a key benefit of attending the Quality and Safety in Children's Health Conference. Take advantage of topic-based roundtables for focused networking and problem solving. Look for a list of table topics posted in The Link.
Educational Sessions

1:15 – 1:45 p.m.

**Addressing Safety Issues with a Comprehensive Workplace Violence Prevention Program**

Grand Ballroom B

Children’s Hospital Colorado developed a workplace violence program that targeted three barriers: 1) inconsistent enforcement of behavioral standard policies, 2) unclear leadership actions when escalations occur and 3) no response when families violate hospital behavioral standards. To address these issues staff trained high-risk locations in de-escalation techniques; developed disruptive behavior bundles to guide staff when patients and families escalate; created an educational document for families that outlines commitment to communication, teamwork and safety; and built a process to document disruptive behaviors in the hospital’s electronic health record with associated leadership responses to provide consistency in charting and tracking supportive actions.

**Katherine Nowacki, M.P.H., CPHQ**
Process Improvement Lead

**Jason Williams, Psy.D., M.S.Ed.**
Director of Operations, Pediatric Mental Health Institute
Children’s Hospital Colorado

**Building an Effective Patient Transition of Care System**

Grand Ballroom A

In 2015, Riley Hospital for Children at Indiana University Health created the Nurse Navigation role to improve care management. Initially, the role focused on transition of care from admission to discharge by providing a consistent team member involved in the patient’s care. Quickly, the role evolved to include more robust involvement in discharge planning and care coordination. The hospital discovered a lack of standard communication processes related to complex patients. Staff refined processes to improve medication compliance, outpatient follow-up and primary care physician communication. They also started an improved discharge process for non-English speaking families.

**Alisha Cook, RN**
Nurse Navigator

**Kelly Orr, RN, B.S.N.**
Nurse Navigator
Riley Hospital for Children at Indiana University Health | Indianapolis
Undetected developmental and behavioral problems in young children can have a profound impact not only on their lives and their families, but also on the community. Through the development of Pediatric Support Services, Children’s Hospital – Greenville Hospital System is addressing the current ineffective system for pediatric screening and referral. The hospital is focusing on capacity-building by developing a mechanism to identify concerns in children earlier and efficiently link families to existing community services.

Kerry Sease, M.D., M.P.H.
Pediatric Support Services
Children’s Hospital – Greenville Hospital System | Greenville, South Carolina

Nationwide Children's Hospital has been at the vanguard of patient safety, but also invests heavily in all Institute of Medicine domains of quality. Their patient-centered Pillars of Quality model rests on a foundation of quality improvement infrastructure and information systems allowing Nationwide to pursue improvement across more than 200 projects in parallel. See what makes Nationwide Children’s Hospital a leader in Quality 3.0, the next generation of quality in children’s health care.

Richard J. Brilli, M.D., FAAP, MCCM
Chief Medical Officer
Nationwide Children’s Hospital | Columbus, Ohio

Couplet care was first introduced in Sweden at the Karolinska Institute in 2007. Staff found that length of stay for those patients decreased, infant morbidity decreased, the parent’s confidence increased, and minimizing separation of the infant and mother led to earlier bonding, attachment, skin-to-skin care, and increased breastfeeding success. Yale New Haven Children’s Hospital was the first U.S. hospital to develop a neonatal intensive care unit and achieved another first when they developed postpartum/NICU mother-baby couplet care.

Marianne Hatfield, M.S.N., RN, CENP
Vice President, Children’s Hospital & Women’s Services

Elizabeth O’Mara, RN, B.S.N., CNML
Patient Services Manager, Women’s Services Postpartum Unit
Yale New Haven Children’s Hospital | Connecticut
EDUCATION SESSIONS

**Increasing Resident Physician Engagement in Safety Through Event Reporting**

*Grand Ballroom B*

Robust safety event reporting is a key component of improving patient safety. While Children’s Hospital of Richmond at VCU’s volume of event reporting was strong, the professional areas reporting were predominantly nursing. To create a more comprehensive safety environment, the organization worked to increase attending and resident participation in reporting. Sequential Plan-Do-Study-Act cycles included: safety event reporting education, active feedback process, patient safety rounds, liaison role between nurses and residents, nursing involvement in feedback, patient safety workshop and breakout projects.

*Jose L. Munoz, M.D.*
Professor of Pediatrics

*Alison Ullman, M.D., FAAP*
Physician
Children’s Hospital of Richmond at VCU | Richmond, Virginia

**Quality 3.0: A Culture of Standardization to Evolve Quality Beyond Safety**

*Grand Ballroom C*

Seattle Children’s was an early adopter of integrating Lean principles into health care. The hospital developed a strong culture of standardization to optimize patient outcomes by eliminating unnecessary variation. For example, more than 80 pathways defining clinical standard work are woven into daily practice, supported by data and measurement to monitor implementation and associated outcomes. Learn about their culture of standardization and the approach to drive and align with the next generation of quality in children’s health care.

*Paul Sharek, M.D., M.P.H.*
Vice President, Chief Quality and Safety Officer
Seattle Children’s
Target-Based Care: Leveraging EHR-Derived Benchmarks to Reduce Postoperative LOS

Grand Ballroom A

Lucile Packard Children’s Hospital at Stanford found the systematic application of clinical pathways to reduce unnecessary variation and waste is costly, resource-intensive and evidence-poor. Consequently, the hospital faced important adoption challenges employing standardized clinical pathways. Staff learned that variation in health care practice exists, in part, due to important variations in mental constructs amongst the practitioners, mirroring the diversity of training, experience and expertise. The hospital used target-based care to promote a shared mental model by establishing clinical targets at the point of care. Staff hypothesize that electronic health record-derived clinical targets can mitigate variation in health care delivery without the need for rigid prescriptive care processes.

Claudia Algaze, M.D., M.S.
Medical Director, Clinical Effectiveness

Andrew Shin, M.D.
Associate Chief Quality Officer
Lucile Packard Children’s Hospital at Stanford | Palo Alto, California

The Harm Index: Capturing the Big Picture of Harm Prevention

Grand Ballroom D

Children’s Hospital of Philadelphia has focused on increasing data accuracy and transparency as a key component of a multi-year approach to formalizing a harm prevention program. The hospital has integrated rate-based metrics and statistical process control charts as one component of this work. To monitor and display overall rates of harm, the organization developed the “Harm Index” as a measure of all events of harm per 1,000 patient days. This data is available at a hospital and unit level and staff can use it in real time to assess variation and statistical improvement in performance.

Anna Frye, B.S., LSSGB
Senior Enterprise Improvement Advisor

Wenjie Song, M.S.
Clinical Data Analyst
Children’s Hospital of Philadelphia
TUESDAY AFTERNOON

3 – 4:30 p.m.

KEYNOTE SESSION with Ingrid Fetell Lee
Grand Salon

Putting Joy to Work

In the pursuit of business success, joy is an attribute that can seem trivial or unimportant. The irony is that joy originally evolved to motivate early human ancestors to pursue goals. Psychologists are beginning to understand that rather than distracting from success, joy actually fuels it. Studies show joyful doctors make better diagnoses, joyful salespeople improve customer satisfaction and joyful employees are up to 12 percent more productive. In this presentation, Ingrid Fetell Lee shows how to bring joy to every level of an organization, from the physical environment to leadership behaviors, to improve employee health and retention, innovation, collaboration and organizational success.

About Ingrid Fetell Lee

Lee is a designer and author whose groundbreaking work reveals the hidden influence of surroundings on our emotions and well-being. The author of Joyful: The Surprising Power of Ordinary Things to Create Extraordinary Happiness and founder of The Aesthetics of Joy, Lee empowers people to find more joy in life and work through design.

Lee has over 12 years of experience in design and branding, most recently as Design Director of global design and innovation company IDEO’s New York office, leading design programs for Target, Condé Nast, Eileen Fisher, American Express, Kate Spade, Diageo, PepsiCo and the U.S. government, among others. Lee holds a master’s in industrial design from Pratt Institute and a bachelor’s in English and creative writing from Princeton University.

THE LINK

4:30 – 6 p.m.

Networking Reception
Galleria Level
WEDNESDAY MORNING

7 – 8 a.m.
Breakfast
Galleria Level

Visit with poster presenters and get your stamps from 7:15 – 7:45 a.m.

8 – 9 a.m.
EDUCATION SESSIONS

Advancing Root Cause Analysis
Grand Ballroom A

Seattle Children’s and Lucile Packard Children’s Hospital at Stanford showcase strategies for improving root cause analysis work through family involvement and process improvement.

Changing the Conversation – Parent Advisors at the Root Cause Analysis Table

Involving family advisors in safety work after an adverse event can be daunting as it exposes some of the organization’s deepest flaws, potentially creating an uncomfortable situation for the organization. However, patients and families are not blind to those flaws and bring a perspective to events as any other discipline routinely invited to the discussion. Seattle Children’s recognizes the importance of having family advisors at the table, the unique challenges identified by both staff and family representatives and shares key learnings from qualitative interviews conducted after root cause analysis cases in which a family representative participated.

Jennifer Faultner
Senior Family Advisor

Sheryl Kalbach, M.S.W.
Patient and Family Experience Specialist
Seattle Children’s

Serious Safety Event Determination Process Improvement

The prolonged time from incident report to serious safety event (SSE) determination resulted in backlog and challenges in addressing the immediate risk mitigation and corrective actions and potentially placed patients at risk. Lucile Packard Children’s Hospital at Stanford created a more effective, streamlined and transparent process for identifying SSE investigations and declaring SSE with local leadership and executive leadership engagement.

Tua Palangyo, RN, M.S.N.
Director, Patient Safety and Professional Practice Evaluation
Lucile Packard Children’s Hospital at Stanford | Palo Alto, California
**Affecting Patient Safety Through Infection Control**

**Grand Ballroom B**

Children’s Health Children’s Medical Center Dallas and Children’s Hospital & Medical Center use their experiences to deliver strategies for providing infection control to patients, families and staff.

**Reducing Hospital-Acquired Conditions with High-Touch Environmental Cleaning Bundle**

An estimated 20-40 percent of hospital-acquired infections such as MRSA, vancomycin-resistant enterococci, C-Difficile, and norovirus can occur from cross contamination by direct contact with the patient’s environment (Weber, et al.). Environmental service personnel often overlook high-touch areas in patient rooms due to patient belongings or medical equipment. Children’s Health Children’s Medical Center Dallas recognized that standardized cleaning of high-touch areas within patient rooms could lead to reduction in infectious outbreaks and hospital-acquired conditions. The hospital identified five high-touch areas that require a medical team member to clean once per 12-hour shift.

**Lindsey Patton, M.S.N., RN, PCNS-BC**
Clinical Nurse Specialist

**Amy Taylor, M.S.N., RN, NEA-BC**
Director, Acute Care Services
Children’s Health Children’s Medical Center Dallas

**Taking Infection Prevention into the 21st Century, Redesigning the System to Avert Error (Safety II)**

Hand hygiene is an essential component of a hospital infection prevention plan. Children’s Hospital & Medical Center struggled to conduct real-time hand hygiene audits, as this was extremely labor intensive and difficult to do discreetly. In October 2015, the organization implemented an automated hand hygiene monitoring system. The system monitors hand hygiene events and opportunities through specifically placed sensors and keyed, user-specific badges. Compliance data is automated and can be reported by unit, area, discipline, or individual. With the use of this technology, the organization set goals to increase the volume of monitored hand hygiene opportunities and decrease the health care associated infection rate.

**Amber R. Phipps, MBA, DBA**
Vice President, Quality and Patient Safety
Children’s Hospital & Medical Center | Omaha, Nebraska
Implementing Change to Improve Care
Grand Ballroom C

Children’s National Health System and Nationwide Children’s Hospital demonstrate how Appreciative Inquiry concepts and a quality improvement-driven morbidity and mortality conference can improve care.

Can Integrating Appreciative Inquiry Transform Culture & Safety?
Children’s National Medical Center undertook the Appreciative Inquiry initiative due to low and waning attendance at weekly Heart Institute morbidity and mortality conferences. Survey feedback from participants suggested that team dynamics had become corrosive—leading to poor outcomes and a toxic environment. Tension and divisiveness between surgeons, intensivists and cardiologists as well as nurses and physicians was cited during town hall style meetings. By integrating Appreciative Inquiry and identifying examples of exceptional team and individual performance to share and explore during a traditional morbidity and mortality conference, the hospital sought to celebrate and learn from outstanding team and individual behaviors despite imperfect systems and challenges.

Lisa Hom, RN, Esq.
Collaborative Practice Facilitator

Darren Klugman, M.D.
Medical Director, Quality and Outcomes for the Heart Institute & CICU
Children’s National Medical Center | Washington, D.C.

Implementation of a Pediatric Surgical Quality Improvement-Driven Morbidity & Mortality Conference
To improve patient care, Nationwide Children’s Hospital sought to develop a new model for analyzing pediatric surgical complications. Staff developed a classification to enhance analysis of complications. Each complication led to identification of failure modes with sub-categorization of root cause, determination of a level of preventability and assignment of discrete action items. Staff reviewed failure determinations to evaluate the distribution of failure modes and action items. Once the hospital established an improved system, staff compared the effectiveness of the revised morbidity and mortality system compared to the National Surgery Quality Improvement Program-Pediatrics in identifying adverse events.

Thomas Bartman, M.D., PhD
Associate Medical Director for Quality

Gail Besner, M.D.
Chief, Department of Pediatric Surgery
Nationwide Children’s Hospital | Columbus, Ohio
Children’s Hospital Colorado and UPMC Children’s Hospital of Pittsburgh showcase how partnerships among departments can produce better data and identify barriers to improve health outcomes.

Leveraging Multidisciplinary Partnerships: Allowing Access to Real-Time Sepsis Data Dashboard
As CHA Improving Pediatric Sepsis Outcomes (IPSO) collaborative members, Children’s Hospital Colorado engaged in applying IPSO work locally. Clinicians, patient information specialists and data analysts partnered to create and validate complex code defining the population and key measures, resulting in monthly data extractions requiring significant resources. As work progressed, it was clear staff needed more frequent data to support improvement, and they expanded their partnership to include the data warehousing team who designed an efficient and reliable structure for real-time reporting. Staff can directly access a dynamic dashboard, allowing them to review and visualize data.

Tod Bos
Data Analyst

Elise Rolison, RRT-NPS
Process Improvement Specialist
Children’s Hospital Colorado

Merging Clinical and Technical Expertise to Drive High-Value Care
Variability between providers and between settings of care results in fragmented and inefficient health care delivery. Using evidenced-based, technology-enabled clinical pathways, in conjunction with user-friendly dashboards, UPMC Children’s Hospital of Pittsburgh created a mechanism for consistent and data-driven insight into variability in practice patterns, resource utilization, and cost by measuring care that is actually delivered, versus order set usage. Their interdisciplinary team includes clinical, IT, finance and marketing expertise to hardwire data-collection, analysis and education. The organization’s team approach has driven process improvement and sustainability.

Gabriella Butler, M.S.N., RN
Manager, Clinical Analytics and Data Science

Denee Marasco
Senior Manager, Information Services Division
UPMC Children’s Hospital of Pittsburgh | Pennsylvania
Quality 3.0: Patient Experience as an Organizing Principle for Driving Quality

Galleria 5

Focusing on the achievement of optimal patient and family experience may serve as a broader and more balanced approach to improving health care quality than traditional work streams. Patient experience encompasses all of the Institute of Medicine domains of quality as well as other dimensions of care including satisfaction, engagement and resilience. Join us to hear about how children’s hospitals are approaching the next generation of quality through integrated patient experience measurement models.

Fiona Levy, M.D., MBA
Executive Director, Sala Institute for Child and Family Centered Care

Paul Sharek, M.D., M.P.H.
Vice President, Chief Quality and Safety Officer
Seattle Children’s

Beth Silber, M.P.A.
Family Consultant
Hassenfeld Children’s Hospital at NYU Langone | New York

9:15 – 10 a.m.

EDUCATION SESSIONS

A Guide to Quality Improvement for High-Volume Pediatric Subspecialty Practices

Grand Ballroom A

Despite institutional support, the pediatric orthopedic, ENT and behavioral health departments at Nationwide Children’s Hospital long struggled to implement formal quality improvement (QI) programs. Pediatric orthopedic and ENT departments had combined clinic visits of more than 70,000. The behavioral health program handled more than 208,000 outpatient visits. Although clinical practice demands are frequently a barrier to such efforts, these very distinct departments used a combination of formal QI training, infrastructure and culture development to become institutional QI leaders.

Kris Jatana, M.D., FAAP
Director, Pediatric Otolaryngology Quality Improvement

Rajeev Krishna, M.D., Ph.D., MBA
Director, Quality Improvement, Behavioral Health Service Line
**WednesDay Morning**

**Julie Samora, M.D., Ph.D.**  
Director, Quality Improvement; Department of Orthopedics  
Nationwide Children’s Hospital | Columbus, Ohio

**Hospitalist Run Discharge Clinics: A Three-Year Retrospective**  
**Grand Ballroom B**

Hospitals, emergency departments (ED) and community practices are increasingly resource constrained due to time, physical space and staffing. These barriers can contribute to access delays leading to ED over-utilization or readmissions and patient dissatisfaction. Penn State Children’s Hospital at the Milton S. Hershey Medical Center discovered how a hospitalist run post-acute care clinic can increase value for an organization, its patients and referral base.

**Michael Beck, M.D., FAAP**  
Vice Chair of Clinical Affairs, Department of Pediatrics  
Penn State Children’s Hospital at The Milton S. Hershey Medical Center  
Hershey, Pennsylvania

**Improving Outcomes for Behavioral Disorder Patients Using Coping Plans**  
**Grand Ballroom C**

To limit disruptive behavior among pediatric patients with autism spectrum disorder or other behavioral disorders when admitted to surgical setting, an inter-professional team at Children’s Healthcare Atlanta convened to determine best practices for addressing and developing a plan of care. The result of the meeting was an individualized plan for children with behavioral disorders. The team developed the coping plan to optimize best practices for all staff caring for patients and families. After a successful trial period, the hospital integrated the coping plan into electronic medical records and any member of the healthcare team can easily access it throughout the continuum of care.

**Tabitha Lyon, M.D., FAAP**  
Assistant Professor of Pediatrics

**Katherine Wittling, MBA, B.S.N., CAPA**  
Manager, Perioperative Services  
Children’s Healthcare of Atlanta
Leveraging the Electronic Medical Record to Improve Sepsis Mortality Rates
Grand Ballroom D

In 2008, Stony Brook Children’s Hospital started a paper sepsis screen at the bedside. In 2013, staff developed an electronic tool that would evaluate data and alert clinicians with real time information from the electronic medical record. Clinicians started using the tool in 2014. The alert informs the bedside nurse when and why a patient meets systemic inflammatory response syndrome criteria. It prompts medical team notification and patient evaluation. With multiple, repeating Plan-Do-Check-Act cycles, the hospital has improved compliance as well as accuracy of the tool.

Carolyn Milana, M.D.
Medical Director, Quality

Grace Propper, M.S., RN, CPNP, NNP-BC
Director, Quality Improvement

Brienna Reid, RN, MSN
Clinical Analyst
Stony Brook Children’s Hospital | Stony Brook, New York

BEE MINDFUL: A Sweet Approach for Children with Special Needs
Grand Ballroom A

Medical settings are often the antithesis of a healing environment leading to delays in procedures and tests, increased safety risks and longer length of stay (LOS). Cohen Children’s Medical Center’s LOS for children with special needs was one day greater than the national average. Key drivers led to the development of an educational module, creation of the Pediatric Neurobehavioral Assessment Tool (PNAT) and a standardized symbol. This standardized PNAT tool captures the specific needs of the child and enables timely medical interventions. With 100 percent practice compliance the hospital attributes the decrease in LOS to the effectiveness of this tool in preventing delays in medical care.

Sharon Goodman, MA, RN-BC, CPNP
Assistant Director, Nursing

Jennifer Simonetti, M.S.N., RN, CPN
Assistant Director, Nursing
Cohen Children’s Medical Center | New Hyde Park, New York
Building a Medical Neighborhood: Integrating Outpatient Clinics

Grand Ballroom B

Over a five-year period, Children’s Hospital of Wisconsin aligned primary clinics into a medical home, facilitated connected care through urgent care and created patient-centered specialty practice (PCSP). The combination—medical home, connected care and PCSP—is the medical neighborhood. It unites 35 clinics and 250 providers. In 2017, the medical neighborhood prevented thousands of unnecessary emergency department visits and saved millions of dollars.

Nathan Fleming, M.D., M.P.H.
Physician Lead, Quality and Health Equity

Robert Rohloff, M.D.
Physical Lead, Quality and Patient Safety
Children’s Hospital of Wisconsin

Care Integration is Essential to Achieving High Value

Grand Ballroom C

Recent CHA facilitated discussions between children’s hospital leaders, clinicians, families, and payers prioritized integrated and coordinated care—and the measures necessary to assess performance in this domain—as being critical to value-based care delivery. Further, this effort highlighted program and measure alignment opportunities to include the family perspective of high-value clinical care and outcomes. Boston Children’s Hospital’s efforts in development and implementation of integrated care models are designed to improve outcomes across the health care continuum. The hospital’s scalable integration models include: measurement framework, tools, performance metrics, and family-reported, informed intervention priorities. Presenters will discuss progress within Boston Children’s Hospital as well as expansion of these efforts to collaborators across the U.S. and internationally.

Richard Antonelli, M.D.
Medical Director of Integrated Care
Boston Children’s Hospital

Sally Turbyville, MA, M.S., DrPH
Sr. Fellow Quality Policy & Research
Children’s Hospital Association
Clinical Impacts of the Improving Pediatric Sepsis Outcomes Collaborative

Galleria 5

Improving Pediatric Sepsis Outcomes (IPSO), a national collaborative of 54 children’s hospitals, aims to reduce mortality from sepsis and improve outcomes by identifying sepsis early and initiating timely treatment. This session will review key drivers for improving outcomes. Presenters will deliver results from the collaborative’s first two years of data, which demonstrate that IPSO strategies are succeeding. More sepsis patients were recognized, bundle use increased, times to antibiotics and bolus decreased, and hospital days decreased. Sepsis-related mortality has also decreased, possibly related in part to improved surveillance. IPSO’s unique design and the exceptional engagement of participating hospitals are creating a strong impact for patients with sepsis.

W. Charles Huskins, M.D., M.Sc.
Vice Chair, Practice and Quality
Mayo Clinic Children’s Center | Rochester, Minnesota

Charles G. Macias, M.D., M.P.H.
Chief Clinical Systems Integration Officer
Texas Children’s Hospital | Houston

Partnerships Serving Families of Children with Severe Behaviors

Grand Ballroom D

Kentucky Children’s Hospital was providing care for an increasing number of children with severe behaviors and faced challenges of sparse care options and year-long waits for care. The hospital collaborated with the College of Education and, as a result of the partnership, timeliness improved. The plan incorporated parents into behavioral interventions which reduced their burden for seeking additional services with improved child outcomes and a model of efficiency for coordination of care. The process of referral, treatment and follow-up will be described.

Allan Allday, Ph.D., BCBA-D, LBA
Associate Professor, Program Director ABA Program

Scottie Day, M.D., FAAP
Physician in Chief

Daniel Larrow, M.D., FAAP, BCDBP
Chief, Division of Development and Behavior Pediatrics
Kentucky Children’s Hospital | Lexington
After Hurricane Maria: Managing Evaporation of the Intravenous Fluid Supply
Grand Ballroom A

The health care system experienced a shortage of IV fluids in 2017, and Children’s Hospital of Philadelphia started an initiative to manage IV fluid use. The hospital observed challenges early in the initiative and restructured creating an IV fluid taskforce to manage conservation and mitigation (C/M) strategies through a formal improvement framework. C/M strategies submitted by any hospital employee were evaluated by unit-based IV fluid champions using a 5-question rubric to estimate perceived impact, patient risk, efforts for implementation, likely benefit and concerns. Clinical taskforce leaders implemented structured changes, monitored processes and measured outcomes.

Lori Handy, M.D., M.S.C.E.
Associate Medical Director, Infection Prevention and Control
Children’s Hospital of Philadelphia
How a Mother’s Story and Sharing Across Hospitals has Transformed Pediatric Safety
Grand Ballroom D

Many children’s hospitals are well on their way to high reliability and over the past two years have decreased serious safety events by 20 percent. Children’s Mercy Kansas City accelerated its efforts after learning about a serious safety event at another children’s hospital that occurred at both organizations. Attendees will hear from a parent whose story has influenced industry changes and is a heartfelt reminder that more work is needed. While there is evidence of some industry improvement, children’s hospitals are doing more to share serious harm in a protected learning organization so serious harm is not repeated.

Carol Kemper, RN, Ph.D., CPHQ, CPPS
Vice President, Quality and Safety
Children’s Mercy Kansas City | Missouri

Deahna Visscher
Patient Safety Advocate
Children’s Hospital Colorado

1:30 – 2:15 p.m.

Learning Collaboratives for Quality Improvement Initiatives in Pediatric Hospital Expansions
Grand Ballroom A

Expanding hospital systems highlight the need for innovative approaches to ensure quality and safety across the organization. Boston Children’s Hospital works to give patients and families the same high standard of care regardless of the treatment location. The hospital built an engaged team of improvement champions equipped with the knowledge and tools of quality improvement (QI) science. To implement change and improve quality and safety of care, staff developed a network-wide collaborative learning group with community hospital pediatric services partnerships consisting of local, interdisciplinary QI teams from each unit.

Melissa Sundberg, M.D.
Director, Quality Improvement Boston Children’s Network Hospitals
Boston Children’s Hospital
Using Clinical Redesign to Enhance Quality and Drive Cost Reduction

Grand Ballroom D

With decreasing reimbursement and increasing costs, it became imperative for Yale New Haven Children’s Hospital to find ways to decrease costs while maintaining high quality care. Recognition of large and complex opportunities to improve care, enhance safety and ensure quality are identified through multiple venues including trended online event reporting, Pediatric Health Information System (PHIS) and staff identification of process inefficiencies. The hospital established an internal consulting group to provide project management, EMR optimization support, and a finance staff liaison to assist with completion of 90-day rapid cycle process improvement projects. Electronic dashboards are developed to track the progress of each project, identify barriers and on-going monitoring for sustainability.

Rebecca Ciaburri, M.S.H.A., B.S.N., RN
Associate Director, Quality, Safety and Program Development

Ryan Davis, M.H.A.
Associate Director, Finance, Strategy & Program Development

Marianne Hatfield, M.S.N., RN, CENP
Vice President, Children’s Hospital & Women’s Services
Yale New Haven Children’s Hospital | Connecticut