The GTC steering committee
David W Roberson, MD, FACS, FRCS
Boston Children’s Hospital
Harvard Medical School
On behalf of
The GTC steering committee

GTC Steering Committee and Friends
Boston, MA, April 2015

Thanks to
Boston Children’s Hospital
Dept of Otolaryngology

What’s the problem?

Tracheotomy-Related Catastrophic Events: Results of a National Survey
Preetty Das, BA*, Hannah Zhu, BA; Rahul K. Shah, MD; David W. Roberson, MD; Jay Berry, MD, MPH; Margaret L. Skinner, MD
Laryngoscope, 122:30–37, 2012

Surveillance and Management Practices in Tracheotomy Patients
Hannah Zhu, MS (Hons)*; Preetty Das, MS (Hons); Jean Brereton, MBA; David Roberson, MD; Rahul K. Shah, MD
Laryngoscope, 122:46–50, 2012

What’s the problem?

Tracheotomy-Related Catastrophic Events: Results of a National Survey. Laryngoscope, 122:30–37, 2012

“Child with T-tube style trach found dead with trach on floor moments before mother was to take child home. Blamed on trach tie being too loose.”

“Accidental decannulation at home of an infant with ventilator dependence due to pulmonary hypertension and resulting hypoxia leading to brain death.”

"Death-mucous plugging at home in child with trach and grade 4 subglottic stenosis.”
What's the problem?

Anecdotes

Can we do better?

Serious clinical incidents

TRAMS Austin Health
Tracheostomy Review and Management Service

- A stand-alone tracheostomy consult service
- Institution-wide protocol-based care
- “Trach days” for staff education
- Accessible educational resources
- Equipment standardization
What's the secret to better outcomes?

Meta-level interventions

- MDT
- Protocols/standardization
- Staff education
- Patient/family involvement

What's stopping us?

- "A tracheostomy is a piece of plastic which lives at the precise intersection of ten different disciplines."
- No 'ownership'

What's stopping us?

- "A tracheostomy is a piece of plastic which lives at the precise intersection of ten different disciplines."
- No 'ownership'
- True multidisciplinary care requires
  - We adjust our schedules
  - We give up some control
  - We prioritize care > department and academic needs
What's a QI Collaborative?
A partnership of hospitals designed to:

- Rapidly disseminate known improvements
- Share data and benchmark
- Share/test novel improvement strategies
- Share/test implementation strategies

How does a QI Collaborative work?
A typical scenario

- Hospitals commit and appoint “champions”
- Often a physical kickoff meeting
- Monthly conference calls/webinars
- Collect data, share outcomes, benchmark

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GTC Steering Committee

- US, Sweden, UK, Singapore, Australia
- ENT, Pulmonary, ICU, Pediatrics, Nursing, Speech, Physio/RT, Family member
- Tracheostomy and QI experts

Date Milestone
July 2012 1st Organizational meeting
April 2013 2nd Organizational meeting
Fall 2013 Beta test database

GTC member hospitals: Expectations

- Leadership commitment
- Annual fee
- Attend a kickoff meeting
- Appoint champions
- “Key drivers”
- Collect data
**GTC “Key Drivers”**

- Multidisciplinary Team Care
- Standardization/ Protocols
- Staff Education*
- Patient/ Family Involvement

**Database**

- Minimum dataset for new trachs ( ~ 10 minutes)
- Emphasis on co-morbidities
- Optional data includes
  - Readmissions*
  - Expanded database**
- Regular* reports and comparisons
- Ultimately -> benchmarking
- Hospitals own their data

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
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<tbody>
<tr>
<td>July 2012</td>
<td>1st Organizational meeting</td>
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<tr>
<td>April 2013</td>
<td>2nd Organizational meeting</td>
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<tr>
<td>Fall 2013</td>
<td>Beta test database</td>
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<tr>
<td>April 2014</td>
<td>USA kickoff (Boston)</td>
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<td>July 2014</td>
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<td>Oct 2014</td>
<td>Australasia kickoff (Melbourne)</td>
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<tr>
<td>Sept 2015</td>
<td>&gt;750 patients in database</td>
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