



# GME QUALITY IMPROVEMENT AND PATIENT SAFETY NEWSLETTER



## MESSAGE FROM THE GME ASSOCIATE DEANS FOR QI & PS



Dear MSHS Residents, Fellows and Faculty,

We would like to begin the first issue of 2022 by acknowledging that the COVID-19 pandemic continues to challenge all of us in so many ways. We understand that safety and caring for loved ones are top priorities right now, and Mount Sinai is working to support everyone in those areas. As a reminder, there are many [well-being resources](#) available including those for self-care, spiritual care, and behavioral health. We hope you will make use of these resources.

The journey to ensure high standards in quality and patient safety is always evolving, and so as we embark into 2022, we would like to highlight a new approach to our goals. In this issue, LeWanza Harris, MD, MPH, MSHS Vice President of Quality and Regulatory Affairs and Oana Randolph, EMPA, RN, MSHS Associate Director of Clinical Integration, present a new approach for achieving QI&PS goals in 2022.

We are also delighted to continue with our "Get to Know Your CMO" series. Paul Yu (GME administrator) spoke with Brian Radbill, MD, FACP and CMO and Senior Vice President of Medical Affairs at Mount Sinai Morningside.

As always, we want to continue to spread the word about reporting serious adverse safety events in SafetyNet. Faculty and trainees whom participate in Root Cause Analysis meetings are certainly aware of this, but as the results of last year's mock CLER site visit suggest, spreading the word is still very necessary. Adverse safety event reporting (via SafetyNet) is vital to our efforts in enhancing the clinical learning environment, and so in this issue, we go into detail about the SAE process. Of course, at the end of this newsletter you will also find the latest SafetyNet reporting trends for the 12-month period, January 2021 through December 2021.

Speaking of getting the word out about these processes, we would like to acknowledge that 61 trainees of various backgrounds and experience signed up to participate in Root Cause Analysis meetings for this academic year. Here, you'll find some feedback about their experience.

Focusing on equity in healthcare is very much a top priority for MSHS, and so we would like to make everyone aware of the Inpatient Quality Dashboard on Tableau. Please read on to learn more. We included links to an FAQ and instructional video on accessing and using this dashboard.

Thank you for reading. We know that times are burdensome right now, and so we cannot stress enough our appreciation for your continued efforts in pursuing quality improvement and patient safety initiatives.

**Brijen Shah, MD**

GME Associate Dean for QI and PS

**Daniel Steinberg, MD**

GME Associate Dean for QI and PS

## CONTENTS

**2022 Quality and Patient Safety Goals - P. 2**

**Get to know the MSM CMO - P. 3**

**The Serious Adverse Events Process - P. 5**

**The Importance of Trainee Involvement in  
Root Cause Analysis Meetings - P. 6**

**QI and Equity: How The Inpatient Quality  
Dashboard Can Help Your QI Project - P. 7**

**SafetyNet Reporting - P. 8**

# 2022 Annual Quality & Patient Safety: A New Approach for Achieving our Goals

LeWanza Harris, MD, MPH, MSHS Vice President of Quality and Regulatory Affairs  
 Oana Randolph, EMPA, RN, MSHS Associate Director of Clinical Integration

Quality and patient safety are fundamental to the well-being of patients, staff, and providers for the continued success of our organization. Over the past 6 months, our organization has launched a new process for setting the annual Quality & Patient Safety (QPS) goals for 2022. The new approach promises to not only address areas of opportunities, but also to highlight new efforts that will enable us, as an organization, to reaffirm our mission of delivering high-quality, safe, equitable, and high-value care.

## What are the QPS goals?

The annual QPS goals are priorities that have been identified as key areas of focus. New categories and domains have been added to the traditional hospital-based quality measures. The new categories and domains include ambulatory, regulatory, behavioral health and advancing equity in quality. Additionally, in 2022 we are leveraging the Donabedian model

of quality to diversify focused measure types. According to Donabedian, information about quality of care can be drawn from three categories: structure, process, and outcomes. See table 1.

## How were the 2022 QPS goals selected?

A multidisciplinary system-level taskforce was convened to determine which identified areas of opportunity should rise to the level of an annual QPS goal. Our performance on over 250 internal and external measures was evaluated. Additionally, organizational priorities and external mandates were reviewed to ensure alignment of goals with the overall strategic plan. The QPS goals were selected based on case volume at risk, alignment with penalty and incentive programs, existing quality improvement efforts, strategic hospital priorities, and anticipated cost.

Table 1

Improvement Category	Measure Type	Goal
Ambulatory	Outcome	Increase the percentage of controlled BP (<140/90) to 75% in patients diagnosed with HTN in ambulatory setting
Regulatory	Process	Achieve ≥90% Overall completion of Always Patient Ready clinical core tracers
Behavioral Health	Process	Achieve 95% Completion of Clinical Global Impression Scale for Ambulatory Psychiatry Patients
Advancing Equity in Quality	Structure	Establish the foundational elements to advance equity in quality
Hospital Readmission	Process	Improve inpatient EPIC documentation for better identification of priority conditions to 80%
Hospital Acquired Infection	Outcome	a. Achieve for each acute care hospital an SIR below 0.75 for the NHSN CLABSI measure b. Achieve for each acute care hospital an SIR below the QHIP cutoff for the CMS reportable HAIs c. Achieve for each acute care hospital a surgical site infection rate lower than the 2019 New York State mean for the procedures reportable only to the New York State Department of Health
Nursing Quality Indicators	Outcome	a. Achieve ≥ 15% reduction in Hospital Acquired Pressure Injuries Stage 2 and above as compared to MSHS prior performance measured as an average over the previous 8 quarters b. Achieve ≥ 15 % reduction in Falls that are of Moderate or Greater Injury Severity and above as compared to MSHS prior performance measured as an average over the previous 8 quarters
Patient Safety	Process	Increase <u>SafetyNet</u> event reporting for the system by 5%
Discharge to Home	Process	Increase discharge to home designation by 5%
Inpatient Patient Experience	Outcome	Increase the percentage of top box patient responses in key domains of Teamwork, Communication (Doctor and Nurse), and Responsiveness

## How will the QPS goals be implemented and evaluated?

For each QPS goal, an executive sponsor and two process owners have been identified. Together with additional key stakeholders, the executive sponsor and process owners will lead a workgroup to achieve the annual QPS goal. To help guide the teams and ensure all deliverables are met based on the proposed timeline, a robust toolkit has been developed. The toolkit outlines the major steps in planning and implementing goal efforts. Additionally, standardized improvement tools and templates will be utilized to facilitate the progress of the efforts to meet the goal.

## Looking forward

We are excited to embark on this new quality & patient safety journey, and we hope you are too!

If you are interested in joining one of the goal-specific workgroups as a house-staff member, please reach out to:

Oana Randolph, EMPA, RN [oana.randolph@mountsinai.org](mailto:oana.randolph@mountsinai.org)

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### Get to Know the MSM CMO

A conversation with Brian Radbill, MD, FACP  
Associate Professor, Nephrology  
Chief Medical Officer and Senior Vice President for  
Medical Affairs, Mount Sinai Morningside



*I had the pleasure of speaking with Dr. Radbill about his role as Chief Medical Officer of Mount Sinai Morningside. Dr. Radbill comes with many years of teaching and leadership experience in Nephrology. His leadership experience spans nearly 15 years, starting off as a Medical Director of a dialysis unit to now being CMO and VP of Medical Affairs at MSM. Dr. Radbill has a lot of great advice, not only for developing leadership skills, but I would also say to approaching life in general.*

*-Paul Yu, GME Administrator, Well-being and Quality Improvement/Patient Safety*

**Dr. Radbill, thank you for taking the time out of your busy schedule to do this. I'd like to start off by asking what you enjoy most about your role as CMO?**

What I love most about it is the opportunity to get involved, to help front-line providers solve what are often seemingly complex problems, but in a way where I am facilitating, coaching, and teaching. I've always enjoyed that aspect of medicine. I think it's really gratifying when I can bring stakeholders together to facilitate discussion, and not necessarily to solve things myself, but help them solve problems in creative ways. At the same time, I enjoy educating folks on the basic tenants of quality improvement, patient safety, and just culture. These are passion projects of mine.

**That's great, and it's interesting to notice from speaking to other CMO's that you all have similar answers in that regard. You mentioned the joy you get from bringing stakeholders together and being an educator, which leads me to my next question: how do you think residents and fellows can help with the safety and quality mission of the hospital?**

That's a great question. There are a few things that residents and fellows can do to begin that process.

I think the first thing is simply identifying opportunities for improvement and reporting safety concerns. The first step to fixing a problem is recognizing that one exists. When trainees are working and learning, they may see things that don't seem safe, or they may have concerns about the way in which care is being delivered; they may recognize inefficiencies. Identifying those opportunities and escalating them to leadership is important.

The next part is that when those opportunities present themselves, trainees should contribute to that process improvement by attending meetings and offering insight. I think that is vital to the safety and quality mission of the hospital. There are more opportunities now than ever (thanks to Zoom) to observe how the hospital addresses safety events and devises root cause analyses.

(continued)

**Obviously you're very experienced, being a physician and teacher in Nephrology, but also as a leader in healthcare administration. I'm sure you have some good advice for those seeking a job in administration. What advice would you give? Maybe you could offer insight as to how you got to where you are?**

Quality improvement and patient safety is front and center of the hospital's values and way of delivering care. I think there are many opportunities for someone who is interested in having a career in healthcare administration.

The first thing I say to trainees and young attendees is to "message your interest." Have a meeting with your manager or supervisor or whomever you report to. Tell them you have an interest in taking on some sort of leadership role relative to your experience. Make sure they are aware of your goals. Make sure to continuously do this throughout your career.

The next step is accepting opportunities that arise. For example, if you have an opportunity that provides you oversight of clinical operations, or if you're given responsibility over a quality or patient safety process, take it! Try to avoid passing on opportunities otherwise you may not get considered in the future. Every opportunity presented to you can be something where you can demonstrate, as I like to say, being an efficient human – someone who brings value beyond just the clinical care they provide. No matter how big or small an opportunity is, the mentality should be "I'm going to take this on and show what I can do." The only way to get good at something is by putting in the reps. Dip your foot in the water!

Lastly, whether it's a formal Masters program, or if it's conferences such as the Institute for Healthcare Improvement conferences as well as their online open school, or a fellowship such as The Clinical Quality Fellowship Program through The Greater New York Hospital Association and United Hospital Fund (I did that program like many others), there are many formal educational options to help build your skill-set.

Ultimately, the path to healthcare administration and leadership requires experience. If you want an informal milestone: you know you're starting to make some headway in the right direction based on the number of valuable meetings you lead. If you are leading a number of meetings, it means you are taking sponsorship and ownership.

One of the best compliments I ever received was, "you really know how to run a meeting!" That's one of the best compliments a leader can receive. Being able to run a valuable and engaging meeting is a skill-set in high demand.

**That's a lot of good professional advice, and I'd even say good advice for life in general! I have one last question: as a very busy person in a leadership role, how do you balance work and personal life? What do you like to do on your free time?**

I like to exercise. During the pandemic, I picked up a Peloton. I've always enjoyed exercising and I think having the Peloton at home makes exercise something I can easily fit into my schedule. I also love going for hikes. I love the Adirondacks, although I don't go nearly as much as I'd like to. But in general, being out in nature and going for a hike is a great way to decompress and clear the mind so I can think about my "passion projects" – I think it's important to have something on the side that is your own – sometimes you need that type of break from everything.

And of course, I love spending that time with my family!

**Exercising the body and mind- all great advice! Thank you again for taking the time to speak with me.**



# The Serious Adverse Events Process: What happens after you submit a SafetyNet Report about an adverse event?

MSHS follows a standard process to understand and learn from adverse events in order to prevent them from happening again. The process follows nationally accepted best practices in patient safety.

## Step 1: Review of SafetyNet Report

All SafetyNet reports are reviewed by senior hospital leadership within 24 hours. Some reports, such as those that focus on the clinical or behavioral actions of an individual provider, are referred to the appropriate department/supervisor for review and follow up. More complex adverse events that involve multiple departments, teams, systems of care or processes enter the MSHS Serious Adverse Events (SAE) process for further investigation.

## Step 2: Debrief and Data Collection

A debrief is held to clarify the timeline of events and focuses on *what* happened, not necessarily *why* things happened or how to prevent them in the future (these are addressed later in the process). Front-line providers directly involved in the event attend and share their recollections of what happened. Debriefs are typically held as soon as possible after an adverse event, ideally within a few days. Providers who cannot attend are contacted and interviewed at a later time. To complement information obtained in the debrief, a team of patient safety specialists will also conduct a chart review, request confidential peer reviews from experts in the field, and obtain input from the patient/family.

## Step 3: Root Cause Analysis

Information from a debrief, chart review, peer reviews and other sources are used to produce a process map, which is a visual representation of the timeline of events. The process map is used to guide a root cause analysis (RCA), which is a formal, structured discussion that aims to identify the reasons *why* the adverse event occurred. The RCA is conducted by patient safety, quality and relevant clinical and non-clinical subject matter experts. Providers directly involved in the adverse event are not allowed to attend the RCA. This is so that the RCA proceedings can remain a quality activity that is protected from legal discovery. At the RCA, the root causes of an event are established. An anonymous vote is also held to determine whether the “standard of care” was met or not, and if not, whether this was due to system or individual practitioner issues. In the vast majority of cases, system issues are found to be causal.

## Step 4: Safety Solution Meeting

Once the root causes of an event are identified at the RCA, a safety solution meeting is held to design corrective actions that will help prevent the adverse event from happening again. Most adverse events have multiple root causes, and a safety solution is developed for each. Safety solutions are designed by a group composed of QI/patient safety experts and the front line providers and stakeholders who will implement and live with the solution. Wherever possible, solutions that correct system defects and that don't rely too much on providers remembering to do things are preferred. Education of providers and staff is a weaker solution than actions that correct structural or process defects. Specific leaders are identified to be accountable for the implementation of each safety solution. Metrics of success are also identified to help determine if a solution has been successfully implemented.

# The Importance of Trainee Involvement in Root Cause Analysis Meetings

You may notice a recurring theme from our talks with MSHS Chief Medical Officers: Resident and Fellow involvement in the Serious Adverse Event reporting process is vital for quality improvement and patient safety. Just as importantly, trainee observation in RCA meetings contributes to the six focus areas of the ACGME's CLER (Clinical Learning Environment Review) program: **Patient Safety; Health Care Quality; Care Transitions; Supervision; Well-Being; and Professionalism.** CLER is designed to improve how clinical sites engage resident and fellow physicians in learning to provide safe, high quality patient care.

We are happy to report that for AY-2022, 61 residents and fellows, across all NYC Mount Sinai Hospital sites, have agreed to participate in RCA meetings. Here are a few comments from participating trainees about their experiences:

**"I found the presentation very clear to follow. It included all the relevant details in terms of background history. Also getting patient information before the meeting is very useful as a practice to think beforehand in terms of "what might be the possible adverse events" in this case. Happy to be a part of RCA committee!"**

**"Very good experience, got a chance to see a rare circumstance with a complication related to my everyday practice. Very beneficial to be able to see the process from the administrative side. Plenty of learning opportunities to take advantage of."**

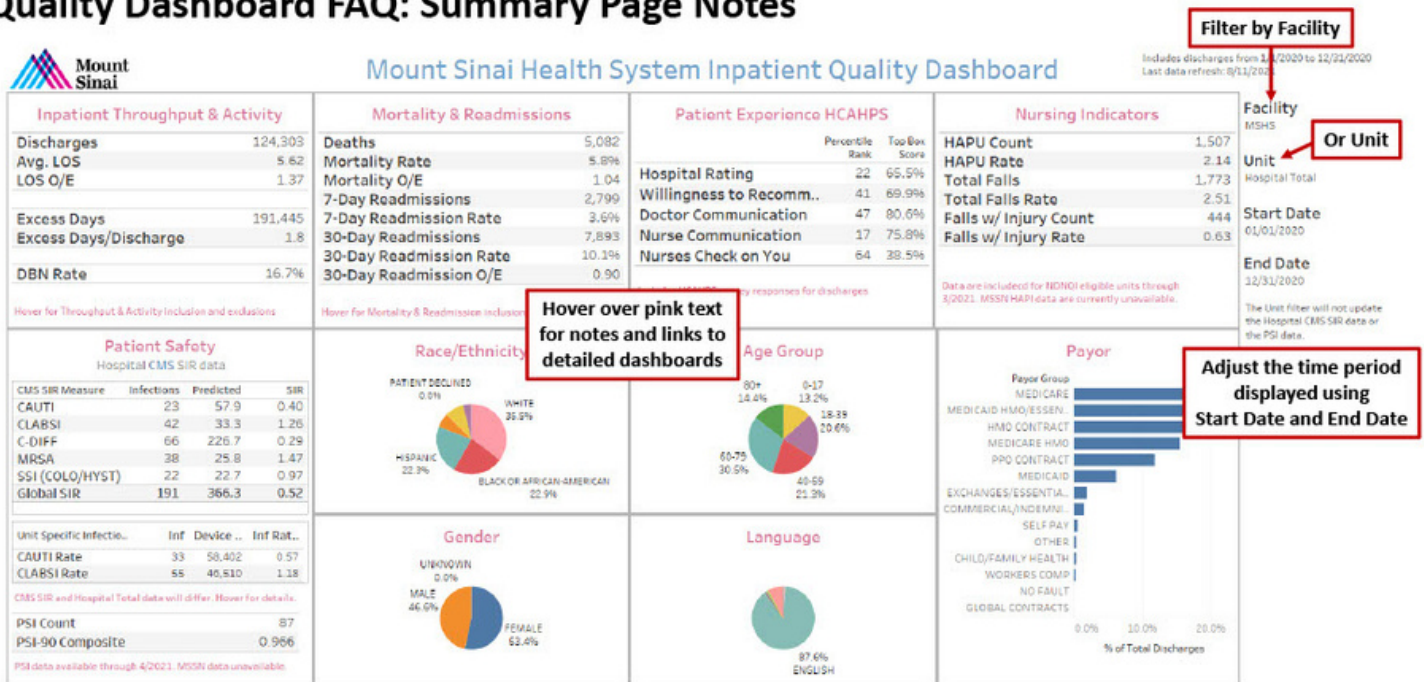
**"Positive experience overall. As a young physician with only a few years of training, I find it very useful observing how more seasoned doctors of different specialties interact with each other, senior nursing colleagues, and pharmacists over sometimes charged cases. The timelines are useful to follow, the RCA run on time and rarely over. Only wish I could attend more."**

The Office of Quality Improvement and Patient Safety is aiming to recruit more residents and fellows to sit-in on RCA meetings. Be on the lookout for an announcement this spring!

# QI and Equity: How The Inpatient Quality Dashboard Can Help Your QI Project

Perhaps you are considering a QI project with a focus on equity or maybe you are interested in how different QI measures are performing. The MSHS Inpatient Quality Dashboard can help. This dashboard is a self-service tool which can be accessed on [Tableau](#). Below is a screen shot of some of its capabilities. We also included links to the informational video and FAQ.

## Quality Dashboard FAQ: Summary Page Notes



Inpatient Throughput & Activity, Mortality & Readmissions, and Demographic data are sourced from MSX (hospital billing data mart). Patient Experience data are from Press Ganey. Nursing Indicators are compiled by Nursing Quality staff. Infection Prevention measures are sourced from NHSN. PSI data are sourced from AHRQ.

If you find that you need permission to access on Tableau, please email [enterprisereporting@mountsinai.org](mailto:enterprisereporting@mountsinai.org)

[Link to FAQ](#)

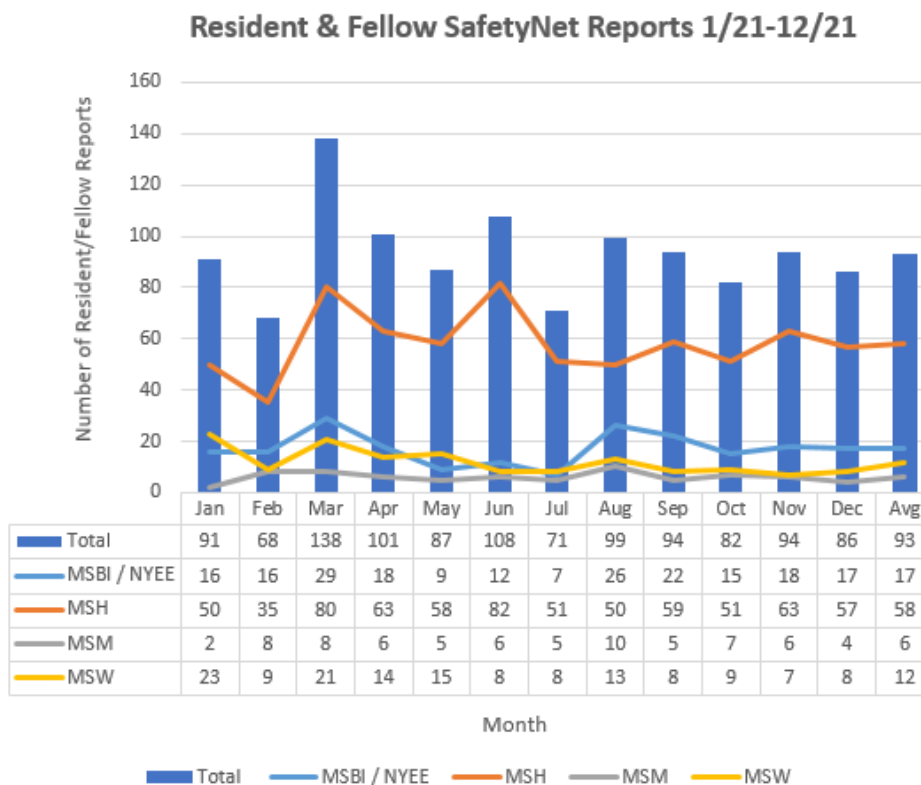
[Link to informational video](#)

The instructional video and FAQ can also be found in New Innovations. Log into NI, click on the "home" icon, and you'll see a section labeled "Curriculum". Click "Quality and Patient Safety Resources > Quality Improvement > Inpatient Quality Dashboard Demo Video"



Below you will find SafetyNet resident and fellow reporting statistics for the 12-month period January 2021 through December 2021.\* The average number of total reports across campuses was 93. March saw the biggest spike in reports at 138, but steadily declined since we instituted our Patient Safety Reporting Challenge.

For those residents and fellows who recently joined us, you should have been oriented to SafetyNet as part of your onboarding. We hope that you will engage with the system and help us in our efforts to continue to develop a culture of patient safety reporting.



### [I entered a report and want to know what happened](#)

A spreadsheet of all residents and fellow entered reports has been posted on New Innovations. You can find your report and the name of the contact(s) for who is handling the case. If the case went to a root cause analysis, the results of the root cause analysis can be found in the spreadsheet as well.

Residents, fellows and faculty are always encouraged to reach out to [Daniel Steinberg](#) (MSBI/NYEEI/MSMW) or [Brijen Shah](#) (MSH) with any questions.

*\*The graph in our previous issue mistakenly listed October 2021 data as total incidents in the month, as opposed to total reports in the month (the date an incident is reported may lag the actual date of incident, which can affect monthly numbers especially as a month ends and another begins). In this issue, October's numbers were adjusted to reflect total number of reports in the month.*