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 start the first issue of 2023 by extending a very sincere thank you to all of the residents and fellows for their dedication and commitment to patient care, quality improvement, and of course safety. We understand that 2023 did not begin under ideal circumstances. As we all know, residents and fellows are a crucial piece of the hospital system's backbone, and so that is why we dedicate a lot of the content in this newsletter to highlighting their projects and achievements.

At the beginning of every calendar year, the Office of the Chief Medical Officer for the Mount Sinai Health System announces system-wide Quality and Patient Safety Goals. Areas of improvement include Ambulatory, Regulatory, Behavioral Health, Advancing Equity, Hospital Readmissions and many more. In this issue, we include the goals for 2023 as written by LeWanza Harris, MD, MPH, MBA, MS and Oana Randolph, EMPA, RN.

As many of you know, the Mount Sinai Health System has a mission to foster a culture of safety, respect, and professionalism. To follow through with this mission, in 2021 the health system established the Committee on Professionalism in Healthcare (COPHE) which developed the Coworker Reporting System (CORS). In this issue, we provide an update on COPHE as well as an Op-Ed from Brianna Hill, MD, PGY-4, MSMW Anesthesiology. As a designated messenger for COPHE, Dr. Hill provides valuable insight as to how this program has developed her skills in communication and conflict resolution.

Leadership within the Mount Sinai Health System are dedicated to improving the workplace environment. In 2021, the Office of the Chief Medical Officer distributed the "Your Voice Counts" survey to faculty, staff, and trainees as a way to gain insight into making MSHS a better place to work and receive care. This survey will be distributed again on March 6, 2023 and will remain open until March 27, 2023. In this issue, you can read more about the survey and its goals.

Positive Patient Experiences is a regular section of this newsletter which highlights patient comments regarding the incredible care they receive from residents and fellows. Please make sure to read and celebrate the trainees who provide such excellent care!

Lastly, we share the latest in QI/PS literature (courtesy of the Agency for Healthcare Research and Quality), as well as MSHS SafetyNet reporting data for the last 12 months. Thank you again for all of your hard work in promoting a culture of safety!

Brijen Shah, MD
GME Associate Dean for QI and PS

Daniel Steinberg, MD
GME Associate Dean for QI and PS

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MSHS 2023 Quality & Patient Safety Goals

LeWanza Harris, MD, MPH, MBA, MS, Vice President, Quality & Regulatory Affairs, Mount Sinai Health System
Oana Randolph, EMPA, RN, Associate Director of Clinical Integration, Mount Sinai Health System

What are the QPS goals?

On an annual basis, our organization develops system-wide Quality and Patient Safety (QPS) Goals based on high-volume, high-risk, and/or opportunities for improvement areas. The priorities also focus on prior annual goals that did not achieve or sustain planned improvement. QPS Goals are established based on quality and patient safety measures from national ranking systems; national, state and federal quality programs; regulatory agencies; professional societies; and organizational strategic priorities as determined by senior leadership and staff feedback. See Table 1 for the 2023 Annual QPS goals.

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 multidisciplinary system-wide 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. Standardized improvement tools and templates will be utilized to facilitate the progress of the efforts to meet the goal. The status of each goal will be assessed regularly and reported to senior leadership throughout the year.

Looking forward

We are excited to continue our quality & patient safety journey, and we hope you are too! If you are interested in joining one of the goal specific workgroups, please reach out to Oana Randolph at oana.randolp@mountsinai.org or LeWanza Harris, MD, MPH, MBA, MS at lewanza.harris@mountsinai.org.

Table 1

Improvement Categories	2023 Annual Quality & Patient Safety Goals
Ambulatory	Increase the percentage of controlled BP (<140/90) to 75% in patients diagnosed with HTN in ambulatory setting.
Regulatory	Achieve ≥90% Overall completion of Always Patient Ready clinical core tracers.
Behavioral Health	Maintain an average of 95% completion of the CGI in 2023.
Advancing Equity in Quality	Establish the foundational elements to screen and report for social drivers of health.
Hospital Readmission	Improve identification of priority disease patients at time of discharge based on EHR documentation to 80%.
Hospital Acquired Infection	a. Achieve for each acute care hospital an SIR below 0.85 for the NHSN CLABSI measure. b. Achieve for each acute care hospital an SIR below the QHIP cutoff for the CMS reportable HAIs.
Nursing Quality Indicators	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.
Safety Culture	a. Increase SafetyNet event reporting for the system by 5%. b. Expand workplace violence prevention training and education.
Discharge to Home	Increase discharge to home designation by 5%.
Patient Experience	Increase the percentage of top box patient responses in key domains of Teamwork, Communication (Doctor and Nurse), and Responsiveness.

Improving Professionalism in the Learning Environement: An Update on the Committee of Professionalism in Healthcare (COPHE)

Melissa Peralta, MPH
Office of the Chief Medical Officer, Mount Sinai Health System

The Committee on Professionalism in Healthcare (COPHE), launched in the summer of 2021, focuses on fostering a culture of safety, respect and professionalism across the Mount Sinai Health System, including the Icahn School of Medicine at Mount Sinai. COPHE aims to address and reduce instances of unprofessional behavior from students, trainees, faculty members, advanced practice professionals, and physicians.

The program consists of delivering feedback to providers and learners who have been reported as having unprofessional behavior using a trained messenger. The messenger provides peer-to-peer feedback, aka a "cup of coffee", about the event. This process identifies unprofessional behaviors and allows individuals to self-regulate without invoking a formal discipline process. For more concerning or ongoing patterns of behavior, a huddle is convened to see if further action or investigation is needed.

Below you will find data overview of COPHE as of January 2023. Additionally, on page 4, you can read an Op-Ed from the persepctive of a resident COPHE messenger written by Brianna Hill, MD, PGY-4, MSMW Anesthesiology.

COPHE Data Overview

Launched program on July 1, 2021

116

trained messengers

As of January 20, 2023

Co-Worker Reports	Count
Messengers Assigned	287
Addressed outside of COPHE	111
Total CORS Reports To Date	**398**
Huddles	122

266 Cups of Coffee Delivered

Who are COPHE Reports about?

Professional Type	Count
Attending	266
Resident	69
APP	41
Fellow	24
Non-Clinical Faculty	16
Graduate Student	4

Audit Period: July 1, 2021 – January 20, 2023

Delivering Cups of COPHE: A Resident's Persepctive

Brianna Hill, MD, PGY-4, MSMW Anesthesia

My journey in healthcare began in college with an academic interest in human physiology. This interest combined with my desire to develop practical skills that could be used to help others led me to apply to medical school.

There, I rotated through different medical specialties before selecting an area where I could see myself fulfilling my aspiration to help others through patient care and ultimately community benefit.

This path, and the reasons for embarking on it, isn't dissimilar from the majority of my co-residents. We've all committed to intense periods of study and training in order to make helping others during some of life's more vulnerable moments our profession.

The rigors and stress of graduate medical training can sometimes obscure the primary interest and hopes that originally directed us toward medicine.

As the training ground for 2,600 residents and fellows annually, Mount Sinai Health System has the opportunity to continue nurturing the original motives that initiated this journey into medicine while trainees move throughout the andragogy specific to each program. One way to create and sustain a learning environment where these ideals are kept alive and embodied in everyday encounters is through programming that prompts self-guided behavior modification and reflection when community standards are not met.

Coworker Reporting System (CORS) aka "The Cup of Coffee Program" was launched across Mount Sinai Health System in July 2021 to intervene when someone has potentially had a lapse in professionalism in a non-punitive manner. The program gently approaches the person before the behavior becomes habitual. Anyone can file a report when they witness or are involved in an event where professionalism standards were not upheld in the view of the reporter. These reports are then externally reviewed, and if a professionalism issue is detected, they are sent back to the Committee on Professionalism in Healthcare (COPHE) at Mount Sinai. The contents of the report are then shared with the involved community member by a trained peer messenger. The intervention is an opportunity for self-reflection and improvement.

Through my involvement as messenger in the program, I have noticed a heightened awareness within myself of how my words and actions might be perceived by others – a sentiment echoed by other resident messengers in the program. I also have a renewed desire to learn more conflict resolution and communication skills with a view of professionalism and collaboration in healthcare as teachable practice.

No matter a resident's specialty or next steps after Mount Sinai, interpersonal conflict and team participation will persist in any environment. Improvement in professionalism skills such communication positively impacts the work communities we are a part of and ultimately patient care. Medical professionalism and the interpersonal and communication skills required deserves attention during graduate medical training and will ensure the original driving forces that brought each of us to medicine persist.

Your Voice Counts Survey

Your Voice, Your Opinion All Count! Tell MSHS what's important to you

Mariana Pugliese, Program Manager, Office of the CMO, MSHS
Rebecca Anderson, Vice President, Office of the CMO, MSHS
Sakshi Dua, MBBS, Professor of Medicine, Program Director, Pulmonary, Critical Care and Sleep Medicine; Director, GME Well-being Champions Program

Residents and fellows, we know you get surveyed A LOT! Most of this is because we have to, in order to meet our regulatory requirements. We want to tell you about a VERY important survey. This survey about safety culture, well being and leadership is THE survey results of which are read by hospital and health system leadership—that means YOUR chairs, hospital Chief Medical Officers and Hospital Presidents! Let them know what you think. Important actionable items will be generated from the information gathered from YOU.

The next confidential Your Voice Counts (YVC) employee engagement survey will be available starting on **Monday, March 6 until March 27.**

Responses to the survey provide important insight into how together, we can make MSHS a better place to work and receive care.

In 2021,over 21,000 faculty, staff and trainees shared their perspectives. We have been working to translate survey results into tangible changes, including safety measures for both you and your patients, employee recognition and well-being.

ONLY 25% of GME trainees took the survey in 2021 and we're looking to significantly increase participation in this important initiative. Residents and fellows are a BIG and important part of our workforce. Don't miss this opportunity to speak up.

We would like to aim for a goal of 50% participation.

If you have any questions, please reach out to yourvoicecounts@mountsinai.org

Positive Patient Experiences

What Patients are saying about MSHS Trainees

Isadora Braune, Patient Experience, Data Strategy & Operations Manager
The Joseph F. Cullman, Jr Institute for Patient Experience

Positive Patient Experiences is a standing section of our newsletter dedicated to celebrating the amazing care MSHS trainees deliver. Here, we will list patient comments (verbatim) which were gathered via paper and electronic surveys. These surveys are distributed to patients who visit the many ambulatory practices across the health system. Click here if you would like to see an example of the survey.

Take a moment to join us in celebrating the latest patient comments about MSHS trainees!

"Dr. Wang was excellent and a great listener."
-Comment left for Denise Wang, MD, MBA, PGY-3, MSH Internal Medicine

"Serious, friendly & very knowledgeable doctor."
-Comment left for Max Dougherty, MD, PhD, PGY-3, MSH Internal Medicine

"Great experience with my primary care doctor. She met my needs asked if my treatment for my condition was working."
-Comment left for Megan Metzger, MD, PGY-3, MSH Internal Medicine

"The doctor is very responsive when I use the messaging center within the Mount Sinai App."
-Comment left for Nicole Casasanta, MD, PGY-3, MSH Internal Medicine

"Dr. Patel [was] excellent. Service always good. Masks worn & hand sanitizer."
-Comment left for Richa Patel, MD, PGY-3, MSH Internal Medicine

In the Literature

Courtesy of the Agency for Healthcare Research and Quality Patient Safety Network

Designing safety interventions for specific contexts: Results from a literature review.
Karanikas N, Khan SR, Baker PRA, et al. Safety Sci. 2022.
Some patient safety interventions, such as checklists, are adapted or borrowed from other industries, such as aviation. This literature review focused on safety interventions developed in one context then implemented in another, such as healthcare. Healthcare was the largest sector represented, with 20 of the 73 included studies.

The impact of meaningful use and electronic health records on hospital patient safety.
Trout KE, Chen L-W, Wilson FA, et al. Int J Environ Res Public Health. 2022.
Electronic health record (EHR) implementation can contribute to safe care. This study examined the impact of EHR meaningful use performance thresholds on patient safety events. Researchers found that neither full EHR implementation nor achieving meaningful use thresholds were associated with a composite patient safety score, suggesting that hospitals may need to explore ways to better leverage EHRs and as well other strategies to improve patient safety, such as process improvement and staff training.

Surveys on Patient Safety Culture (SOPS) Hospital Survey 2.0: 2022 User Database Report.
Hare R, Tapia A, Tyler ER, Fan L, et al. Rockville, MD: Agency for Healthcare Research and Quality; October 2022. AHRQ Publication No. 22(23)-0066.
Instituting a "culture of safety" is fundamental to ensuring patient and staff safety. The AHRQ "Hospital Survey on Patient Safety Culture" (SOPS) is a validated survey that has been widely used to assess patient safety culture since 2004. The 2022 report includes data from over 400 hospitals. The highest "percent positive" composite measure scores included both effective teamwork and supervisor, manager, or clinical leader support for suggestions for improving patient safety, and addressing patient safety concerns. Overall, when asked to rate their unit/work area on patient safety, 67 percent of respondents rated their unit/work area as "Excellent" or "Very Good."

Influencing a culture of quality and safety through huddles.
McCain N, Ferguson T, Barry Hultquist T, et al. J Nurs Care Qual. 2022;Epub Aug 19.
Daily huddles can improve team communication and awareness of safety incidents. This single-site study found that implementation of daily interdisciplinary huddles increased reporting of near-miss events and improved team satisfaction and perceived team communication, collaboration, and psychological safety.

Implementation of the I-PASS handoff program in diverse clinical environments: A multicenter prospective effectiveness implementation study.
Starmer AJ, Spector ND, O'Toole JK, et al. J Hosp Med. 2022;Epub Nov 3.
I-PASS is a structured handoff tool to enhance communication during patient transfers and improve patient safety. This study found that I-PASS implementation at 32 hospitals decreased major and minor handoff-related adverse events and improved key handoff elements (e.g., frequency of handoffs with high verbal quality) across provider types and settings.

Examination of maternal near-miss experiences in the hospital setting among Black women in the United States.
Byrd TE, Ingram LA, Okpara N. Womens Health (Lond). 2022;18:174550572211338.
Maternal near misses are associated with lower quality of life and poorer outcomes for the pregnant person and their family. In this study, 12 Black women who experienced a maternal near miss describe major contributors. They list communication problems, such as not being believed, their relationship with their provider, and provider discrimination as major contributors.

Factors that affect opioid quality improvement initiatives in primary care: insights from ten health systems.
Childs E, Tano CA, Mikosz CA, et al. Jt Comm J Qual Patient Saf. 2022;Epub Oct 22.
In response to the increase in opioid deaths, the Centers for Disease Control and Prevention (CDC) released the Guidelines for Prescribing Opioids for Chronic Pain in 2016, with an update released in 2022. This study reports on the CDC Opioid QI Collaborative which was launched to identify successful evidence-based strategies for implementing the guidelines. The challenges and strategies described in the publication can be used by health systems to accelerate implementation of the guidelines.

A failure in the medication delivery system - how disclosure and systems investigation improve patient safety.
Lucas SR, Pollak E, Makowski C. J Healthc Risk Manag. 2022;Epub Dec 4.
Medical errors that receive widespread media attention frequently spur health systems to reexamine their own culture and practices to prevent similar errors. This commentary describes one health system's effort to identify and improve the system factors (systems, processes, technology) involved in the error. The action plan proposed by this project includes ensuring a just culture so staff feel empowered to report errors and near-misses, regularly review and improve medication delivery systems, build resilient medication delivery systems, and establish methods of investigations.

The safety of inpatient health care.
Bates DW, Levine DM, Salmasian H, et al. New Engl J Med. 2023;388(2):142-153.
An accurate understanding of the frequency, severity, and preventability of adverse events is required to effectively improve patient safety. This study included review of more than 2,800 inpatient records from 11 American hospitals with nearly one quarter having at least one preventable or not preventable adverse event. Overall, approximately 7% of all admissions included at least one preventable event and 1% had a severity level of serious or higher.

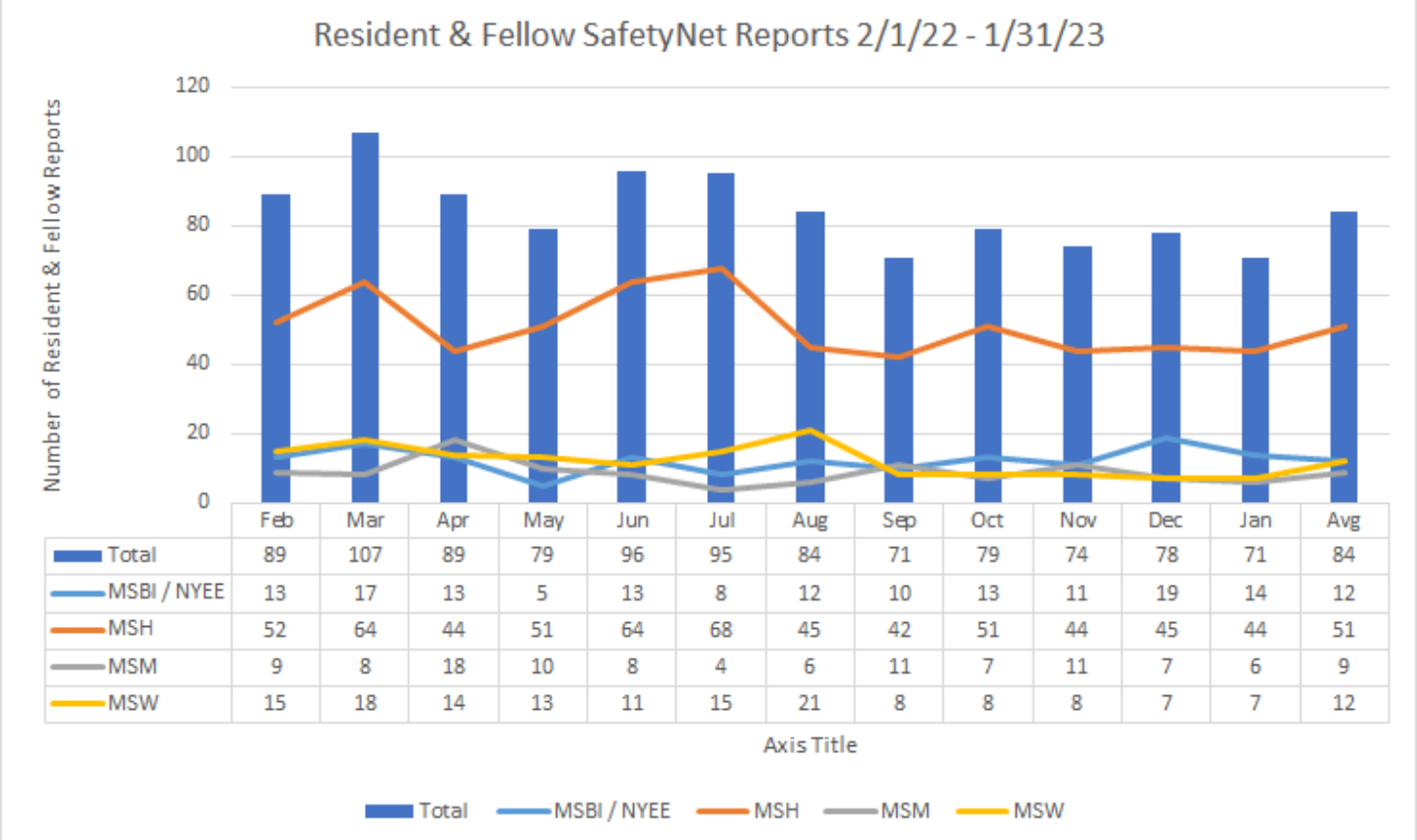
Leadership behavior associations with domains of safety culture, engagement, and healthcare worker well-being.
Tawfik DS, Adair KC, Palassof S, et al. Jt Comm J Qual Patient Saf. 2022;Epub Dec 23.
Leadership across all levels of a health system plays an important role in patient safety. In this study, researchers administered theï¿½Safety, Communication, Operational, Reliability, and Engagement (SCORE) survey to 31 Midwestern hospitals to evaluate how leadership behaviors influenced burnout, safety culture, and engagement. Findings indicate that local leadership behaviors are strongly associated with healthcare worker burnout, safety climate, teamwork climate, workload, and intentions to leave the job.

Untenable expectations: nurses' work in the context of medication administration, error, and the organization.
Hawkins SF, Morse JM. Glob Qual Nurs Res. 2022;9:233339362211317.
Medication administration is a complex set of tasks completed many times per day for hospitalized patients. This study captures the turbulence of nursing work, the nursing environment, and how that impacts patient safety. The results suggest organizations should re-evaluate current attempts at improving medication administration safety and include nurses in identifying new solutions.

SafetyNet

Below you will find SafetyNet resident and fellow reporting statistics for the 12-month period February 1, 2022 - January 31, 2023. The average number of total reports across sites remains unchanged since our last report (84). The total reports of all sites during the months of September 2022 through January 2023 were below the total average for the 12-month period. March continues to be the month with the most reports likely due to the yearly 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.



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Avg
Total	89	107	89	79	96	95	84	71	79	74	78	71	84
MSBI / NYEE	13	17	13	5	13	8	12	10	13	11	19	14	12
MSH	52	64	44	51	64	68	45	42	51	44	45	44	51
MSM	9	8	18	10	8	4	6	11	7	11	7	6	9
MSW	15	18	14	13	11	15	21	8	8	8	7	7	12

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.