GME Patient Safety & Quality Improvement Newsletter

Featured in This Issue

Message From Dr. Brijen Shah

I hope that everyone had a wonderful summer. To those of you who are new to Mount Sinai Hospital, I hope that you have settled into your new home. As the academic year gets into full swing, we highlight some helpful resources in this issue including how to request data for your QI projects and a unique patient safety grant opportunity.

In the coming months, we launch two exciting programs. The Mount Sinai Experience kicks off with an interdisciplinary training to help us transform our Patient Experience. The MSHS will launch a new event reporting system to have frontline providers report safety events. Stay tuned for more information about the system!

Sincerely,

Brijen J. Shah, MD
Associate Dean for GME in QI/Patient Safety,
Mount Sinai Hospital

Meet the Mount Sinai Health System Deputy CMO

Marc Napp, MD
Senior Vice President, Medical Affairs
Deputy Chief Medical Officer at Mount Sinai Health System

Unlike the other five chief residents graduating from Mount Sinai's General Surgery Residency Program in 1990, I was eager to finish my training and dive right into surgical practice. As the exception, I sought not to do a fellowship or stay in academia. My role models had been the most prominent surgeons at MSH – busy, highly respected, and extremely talented private practice surgeons. Additionally, 1990 saw NY City's first laparoscopic cholecystectomy. Dr. Barry Salky, a visionary regarding the use of laparoscopy for intra-abdominal surgery, traveled to France to learn the technique and arrived back at MSH looking for the perfect patient to be his first case. I found such a patient at the Elmhurst General Surgery Clinic and referred the case to him. As a "reward," he let me hold the camera. It was brutal. The case took over four hours, visualization was poor, the instrumentation was rudimentary, and the crowd in the OR was intimidating. That experience, however, assured my interest in minimally invasive surgery.

I left MSH for Danbury Hospital in Danbury, CT, a community teaching hospital staffed by university-trained specialists who practiced high-quality medicine, but without a surgical house staff. My practice flourished and within a year I was the busiest surgeon in the community, partially due to my head start in laparoscopy. What I soon came to recognize, however, was that learning to perform advanced minimally invasive procedures, such as laparoscopic splenectomy, fundoplication, and bowel resection, outside of a residency training program, presented me with a moral dilemma – do I only gradually gain competence to do these procedures along a protracted shallow learning curve, or do I send the cases to Yale or NY City where surgeons were already formally trained to do them. I was in a quandary.

The other dynamic that was playing out in my professional development was a proclivity for systems thinking. It presented itself in a number of ways: I asked to and was given the opportunity to overhaul and lead the peer review and quality improvement processes for the Department of Surgery; I was appointed chair of the Medical Records Committee, ushering in the use of order sets and templated notes; I started the Medication Occurrence Project to address medication errors; I led the hospital's first root cause analysis; I developed the hospital's first surgical practice guideline to streamline and standardize care; and I became the hospital's first medical advisor to Case Management. Except for a small stipend for chairing the Medical Records Committee, I performed all of these activities as a volunteer without compensation and without "protected time."

Eager to advance my passion for process improvement and to learn more about organizational behavior and management, I enrolled in the University of Wisconsin's Master of Science in Administrative Medicine Program. Ultimately, that experience led to my recruitment into a full-time administrative role as VP for Medical Affairs at a small community hospital in Westchester County.

What is your role as the Deputy Chief Medical Officer for the Mount Sinai Health System?

As background, the role of a hospital's lead physician executive has evolved over the past four decades. Originally, the "Chief of Staff" was a member the medical staff elected by his/her peers to chair the Medical Executive Committee, the guiding body of the Medical Staff. With increasing regulatory burden, various agencies instituted requirements that hospitals appoint a Medical Director, someone accountable to the Governing Body, not just to the Medical Staff. The Medical Director was responsible for ensuring that all regulatory and accreditation requirements were fulfilled, often because the Chief of Staff and the Medical Staff were not focused on those mandates. To assign the Medical Director a position within the hospital's table of organization, the Medical Director was granted the title of Vice President for Medical Affairs (VPMA). More recently, in efforts to recognize the strategic responsibilities of the VPMA, that position has frequently morphed into the Chief Medical Officer.

My position is a bit of a hybrid, since I am the Senior VP for Medical Affairs and Deputy Chief Medical Officer, an arrangement that is specific to the Mount Sinai Health System. My responsibilities are quite broad and varied.

They include:

- Supporting the MSHS CMO
- Providing oversight, guidance and back-up for the hospital CMOs in regard to their myriad responsibilities
- Overseeing credentialing and privileging across the Health System for all licensed independent practitioners and advanced practice providers
- Overseeing compliance with regulatory requirements and accreditation standards for the Health System, as pertains to clinical activities
- Driving coordinated systemization of processes across the Health System
- Ensuring that Medical Staff operations run smoothly
- Mentoring staff members to achieve their performance and career objectives
- Leading efforts to build capacity and capability to manage change and drive improvement across the Health System
- Leading the Health System's emergency management program

What are the top three quality and safety priorities you see for the Health System?

Not in any particular order:

- Standardization of processes
- Making safety and improvement a priority in themselves
- Situational awareness and organizational mindfulness

How can residents and fellows be involved in advancing the quality and safety mission of the Health System?

- As trainees, residents and fellows should focus on learning and on discerning, of the practices that they observe, which to emulate and which to disregard.
- The provision of health care is much greater than the procedures one learns to perform and the treatments one learns to administer. The overemphasis on gaining medical knowledge and developing technical skills, at the expense of understanding and promoting professionalism and systems-based practice, impede the neophyte physician's maturation. Unfortunately, the apprenticeship model of medical education requires the passage of at least one or two generations before new ways of thinking are adopted and old ways, retired.

- Therefore, my advice is to be inquisitive and questioning. To learn to think critically about problems and how they must be solved. To embrace the soft skills of emotional intelligence, critical listening, negotiation, and mindfulness.
- Finally, I recommend participating in any exercise that expands your exposure to serious safety event analysis, clinical ethics, high reliability, just culture, and practitioner wellness.

If you were a resident now and had an interest in quality improvement and patient safety, what would be important learning or training experiences to have now to have a career like yours?

I think it's critically important to identify mentors to help you steer your course and to help you answer the challenging personal questions and the nagging, unsettling doubts that inevitably will arise. In a highly competitive environment, it can be difficult to know whom to trust and who has your back. Additionally, in a high stress, high stakes environment, it can be difficult to deal with errors and failures. One's well-being and that of his/her patients, colleagues, and family can depend on how effectively these matters are addressed.

I wish I could tell you that the health care industry is nurturing, sensitive, empathic and understanding, but it's not, as you've surely figured out by now. It takes grit to survive and prevail and it takes self-awareness and self-modulation not to become a slave to that grit, as we toil under intense scrutiny and demands to be mistake-proof. Rather than focus solely on self-preservation, try to help raise awareness to system faults and then work openly and collaboratively to confront and correct them. Seek opportunities to participate in critical event evaluations, such as root cause analysis. Observe different ways in which peer review is conducted – which methods result in learning, which in paranoia. Learn about leadership by watching those in authority and how they exercise that authority. Leaders are not only at the top of an organization . . . they also lead resident teams, direct clinics, run teaching rounds, and manage crises on the fly.

Look around the organization for instances of successful change management. Since all improvement requires change, and change is hard to swallow, effective change management necessitates a specific skillset that I believe is rare among classically trained clinicians. Change management is not part of the standard medical, nursing or pharmacy curriculum. If you cannot find clinicians with the skillset, look for non-clinicians. Departments with formally trained project managers may be a good resource.

Lastly, roll up your sleeves and look to get your hands dirty addressing processes that are broken – there's no shortage. Follow my example and do it without expecting compensation or even a pat on the back. Do it because you care and because you want to learn.

Daily ESQ Huddle
Shirish Huprikar, MD MSH CMO

For hospitals on the path to becoming a High Reliability Organization, a safety huddle is an essential tool to operationalize. The Mount Sinai Hospital (MSH) launched a safety huddle Monday through Friday at 8am starting in June 2018. To emphasize our mission, we call it the MSH Experience Safety Quality Huddle (ESQ).

Experience Safety Quality (ESQ) is a daily safety huddle at The Mount Sinai Hospital where departmental leadership and unit management from all areas come together to share information about potential or existing problems facing patients or staff.

It is led by the Chief Medical Officer (or another designated hospital leader) and includes leadership from all inpatient units, Nursing, through out, major clinical departments (e.g. Medicine and Pediatrics), hospital departments (e.g. Infection Prevention, Risk Management and Patient Safety, etc.), and ancillary support services (e.g. Environmental Services, Transport, Pharmacy ,etc.).

The goal of ESQ is to share information about problems that may be a risk for patients or staff. By focusing on significant safety or quality issues from the prior 24 hours and anticipated issues in the upcoming 24 hours, ESQ has emerged as the central platform to communicate real-time safety concerns so that relevant stakeholders can quickly mobilize to implement effective solutions.

A project manager in the Office of Excellence in Patient Care oversees a daily check-back process to ensure all identified concerns have a call to action. ESQ has successfully increased safety awareness among leaders and frontline staff. ESQ also provides a forum to educate, reinforce and motivate teams regarding safety initiatives and best practices. With the definitive goal to foster a culture of safety, ESQ will continue to evolve to achieve our mission of ensuring optimal experience, safe care, and high quality.

One example of an issue raised by a resident at a recent Dr. Reich Breakfast Meeting, which the huddle tackles, are patients who are waiting for beds in the PACU. This throughout issue is raised and appropriate leaders brainstorm how to respond. It allows for greater situational awareness of the problem every day.

Through the organization of a daily check-back process to ensure all identified concerns have a call to action, ESQ has successfully increased safety awareness among all rankings of staff. Simultaneously, ESQ has become a forum to educate, reinforce and motivate teams on current and future safety initiatives and best practices. With the definitive goal to foster a culture of safety, ESQ looks forward to evolving with patients and staff in mind.

Want to learn more, please contact Melanie Dell, melanie.dell@mountsinai.org!

The Patient Experience, Makaya Saulsberry, Director - Cullman Institute for Patient Care

Since coming together as a health system, we have made tremendous strides. We are extremely proud of our outcomes, growing reputation, and the dedicated efforts of our staff. However, we are committed to continually raising the standard of care and service! We must always be improving the experience of our patients and their families. Our continued success depends upon consistently delivery safer, high quality care while putting the patient at the center of everything we do.

The next phase of our work together will begin this fall as we all participate in a system-wide initiative entitled **The Experience.** This is a 4-hour workshop that will bring us together in small groups to help shape our future. In these sessions, faculty and staff at all levels of the organization will participate in interactive discussions about what motivates them in their role and where we can work better together. The goal of The Experience is to unify all employees around a shared vision for the patient, family and caregiver experience. This is about our patients receiving safe, high-quality care in an environment where they feel cared for during each and every encounter with us. Every member of The Mount Sinai Hospital community will attend one session. These sessions will be interactive, engaging and center around a visual guide, which will be used to display the ideal state of the patient experience at MSHS. We can't wait to learn from you!

Julia Blanter, MD
Internal Medicine, PGY-2

A House Staff Quality Improvement Project Reducing the Number of Lab Draws Inpatient

Jared Ditkowsky, MD
Emergency Medicine, PGY-3

Patients admitted through the emergency department often end up receiving extraneous labs. Upon arrival to the Emergency Department, certain labs are drawn and ordered per emergency protocol. Once admitted, new medicine teams proceed to order similar labs. Often this increases burden on the nursing staff in the emergency department as they are the ones responsible for all lab draws for their patients. Unfortunately, there is no dedicated phlebotomy service as there is on in the inpatient wards.

Emergency department resident Jared Ditkowsky and Internal Medicine resident Julia Blanter have teamed up to research the major culprit in duplicate labs that are ordered. They devised a general guideline based off of extensive chart review of newly admitted patients. This guideline serves to advise which labs can/should be re-ordered upon admission to general medicine. The results of this review and the guideline will assist in working to hire dedicated phlebotomists in the emergency department, decreasing the lab draw burden on nursing staff. The hope is that morning labs will be drawn in a more timely manner without orders missed and duplicate/extraneous lab orders will be avoided. As the project continues, Jared and Julia hope to expand this into a hospital wide project, decreasing the human and monetary cost of extraneous labs ordered and drawn.

Accreditation Council for Graduate Medical Education

ACGME Healthcare Disparities Learning Collaborative Update

Dr. Rui Jiang, Preventive Medicine PGY-5

As a part of the inaugural ACGME Healthcare Disparities Learning Collaborative to improve the clinical learning environment, Mount Sinai Hospital and Mount Sinai Beth Israel have gathered a group of residents with a robust hospital leadership team to discuss our greatest opportunities in improving healthcare disparities in the patients we see every day.

The overall goals for the collaborative were clarified in the three-day training in June 2019 with training programs around the country at the ACGME headquarters in Chicago, and they are as follows:

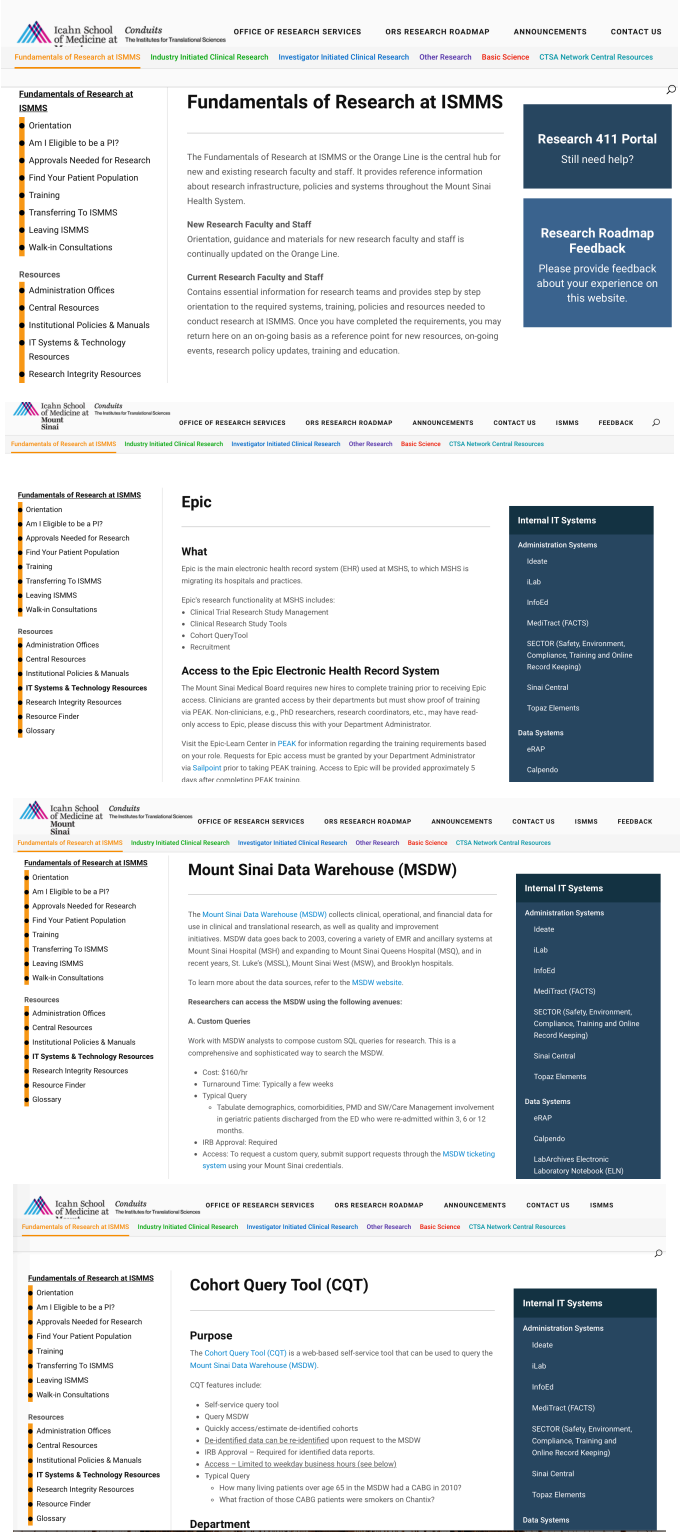
1) Develop and align strategic goals and priorities to identify and eliminate differences in the care delivered within the clinical learning environment through quality improvement.
2) Promote awareness and recognition of cultural humility across the clinical learning environment that reflects the cultural diversity of its workforce and patient population.
3) Educate new clinicians on identifying health care disparities occurring within the clinical learning environment and the patient populations at risk for these disparities, which includes an understanding of both health and health care disparities.

One of the take-aways from the three-day training was a deeper appreciation of cultural humility, which is defined as the personal reflection and growth about culture in order to increase a service provider's awareness. A faculty gave an example of how he clinically practices cultural humility by having a time out for learners to identify power imbalances before a patient encounter. The goal of cultural humility is not to achieve a certain behavior or knowledge but to encourage a moment by moment learning that will be lifelong.

To tackle the development of strategic goals and priorities around healthcare disparities, our group will collaboratively develop a strategic plan for addressing the topic of healthcare disparities within GME with the input of MSH, MSBI and MSHS leadership and School leadership. Meanwhile, we have been conducting learner and faculty assessments concerning the attitudes towards the use of race/ethnicity data (RED) as well as sexual orientation and gender identity (SOGI) data in clinic practice at Internal Medical Associates (IMA) and General Medicine Associates (GMA). We found that residents are interested in learning how to use RED and SOGI data in their clinical practices. In our workgroup discussion, many residents supported to incorporate cultural humility into our final interventions. We are in the process of finalizing our interventions and hope to carry them out in the fall.

We hope that this project will expand beyond the internal medicine clinics and into all areas of medicine and surgery because healthcare disparities have no boundaries. We are fortunate to have strong hospital and GME leadership to support trainee's initiatives. We encourage all residents who are interested to be involved to contact us (rui.jiang@mssm.edu or emily.hertzberg@mssm.edu).

NEED TO FIND DATA FOR YOUR QUALITY IMPROVEMENT PROJECT?



The Mount Sinai Icahn School of Medicine Institute for Translational Sciences (ConduITS) has developed a new website to help guide users through the data acquisition process. The web site, Research Roadmap, can be found at: http://researchroadmap.mssm.edu/reference/

The Find your Patient Population link will lead you to instructions for the two major repositories for data—the Epic electronic health record system (EHR) and the Mount Sinai Data Warehouse (MSDW). There are links within each section that illustrate the features of these two resources, training materials, and how to make a data request. With appropriate approval letters for QI projects, there is no cost to make a data request from the Epic Reporting Team or the MSDW.

Click here and find how to make "Epic Data Requests": http://researchroadmap.mssm.edu/reference/systems/epic/ .

Click here and find how to make MSDW Custom Queries: http://researchroadmap.mssm.edu/reference/systems/msdw/ Note: There is a charge for research-related data requests, but not for approved QI projects.

Residents and programs looking for data for a Quality Improvement project may find Slicer Dicer a useful tool. Slicer Dicer is an Epic-based self-service cohort query tool that allows users to have quick views into patient populations. Slicer Dicer data are pulled from the Epic EHR's backend data warehouse (Caboodle). Data in Slicer Dicer are current through the prior day.

For more information, go to: http://researchroadmap.mssm.edu/reference/systems/epic/#slicer-dicer.

You may also want to explore the self-service cohort query tool for MSDW, CQT. For CQT click here:

http://researchroadmap.mssm.edu/reference/systems/cohort/

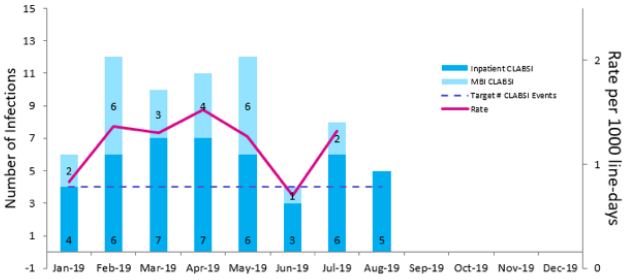
Central Line Associated Bloodstream Infection (CLABS)

Dr. Sarah Schaefer, *Assistant Professor Infectious Disease*
Dr. Gopi Patel, *Associate Professor Infectious Disease*

Approximately 30,000 CLABSIs occur annually in the US and are associated with increased healthcare costs, prolonged length of stay (on average 10 days), and up to 25% mortality. It is estimated that 70% of these CLABSIs are preventable.

Each and every CLABSI is a patient safety event and we are all responsible for preventing these patient safety events. At Mount Sinai Hospital we had 56 patient safety events due to CLABSI in 2018 and we have had 45 so far in 2019.

MSH CLABSI 2019
(MSHS Target – 0.75 CLABSI per 1000 catheter days)



Year	Number*	Predicted	SIR	Rate
2018	56	64	0.8	1.0
2019 (up to Aug)	43	42	1.0	1.3

* Non-MBI CLABSI

What can you do?

1. Choose the right line for your patient:

Not all patients require central or peripheral access while in the hospital!

Location	Device Type	≤ 4 days	5-28 days	≥ 31 days
Bedside, Line Team Room, ED or Outpatient	Peripheral IV Catheter			
	Midline Catheter	Preferred to PICC if proposed duration ≤ 28 days		
	Non-tunneled / Acute Central Venous Catheter	Preferred to PICC for use ≤ 14 days in acutely critically ill patient		
	PICC		Proposed duration is ≥ 6 days and preferred to tunneled catheters for durations of 15-30 days	
OR or IR	Tunneled Catheter			No preference if use is ≥ 31 days
	Port / Implantable port			

A. Think about anticipated duration and indication for any central access.

B. Utilize the MSH Vascular Access Algorithms to help with line selection and the VAS and VAST Teams for line placement:

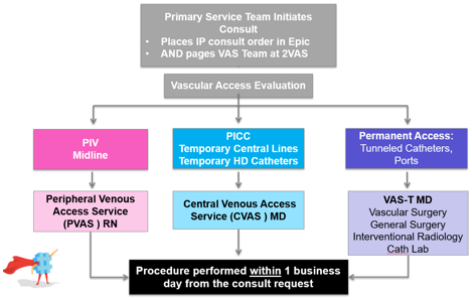
I. Place consult order in EPIC AND page VAS Team @ 2VAS

2. Reduce the number of times your patient's line is accessed:

a. Convert medications from **IV to PO** as soon as possible

b. Review all medications daily and discontinue medications that are no longer needed

c. Batch blood draws and discontinue daily draws when not indicated



3. Evaluate and discuss the line EVERY day on rounds:

A. 21% of clinicians are unaware their patient has a central line, don't be one of those clinicians!

B. Remove the line as soon as possible

I. The VAS tram is available if you have trouble getting venous access (PIV) or need Extended Dwell PIV for longer duration treatments (e.g. antibiotics).

#ZeroCLABSI

MSHS Medical Liability Risk Reduction Innovation Grant

The application deadline is November 1, 2019 with funding decisions by end of November 2019.

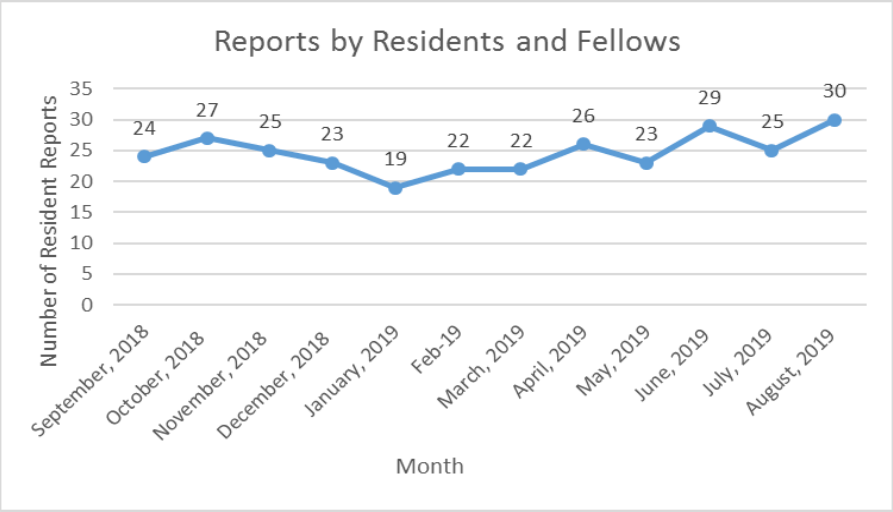
The MSHS - Medical Liability Risk Reduction Innovation Grant program aims to encourage and support activities that will address Healthcare Risk Advisors' (HCA) mission to reduce malpractice risk. We are looking to fund projects that specifically address events that result in known malpractice loss, like decreasing diagnostic errors, or improving clinical skills. The amount of the award is up to $50,000 for the entire term of the project, and is inclusive of indirect costs (maximum of 15%). Awards are made to sponsoring institutions, not individuals or departments. The principle investigator (PI) must be an MSHS hospital employee or a clinician with HIC professional liability insurance. Trainees are not eligible to serve as a PI. Each submission should include cover letter, project description, and CV of the PI. The completed grant application should be emailed to David L Feldman, MD SVP & CMO at dfeldman@TDCHRA.com.

If you are interested and to request more information contact Dr. Michael Brodman and Bonnie Portnoy, MJ BSN

The HIC currently is funding the following innovation grants:

- Health Literacy Assessment / Patient Satisfaction in Surgeon-Patient Communication
- Professional Coaching in Surgery
- Introducing Clinical Event Debriefing into the Pediatric ICU and Rapid Response Team
- Case-based Simulation Training for non-pediatric Trained Emergency Medicine providers
- Enhanced Communication strategies during high-risk patient encounters

MERS - Event Reporting



Report a Patient Safety Event

mers.mountsinai.org