GME QUALITY IMPROVEMENT AND PATIENT SAFETY NEWSLETTER

MESSAGE FROM THE GME ASSOCIATE DEANS FOR QI & PS

Dear MSHS Residents, Fellows and Faculty,

For our first issue of the 2024-2025 academic year, we would like to welcome all incoming residents and fellows to the Mount Sinai Hospital System! Now that onboarding/orientation season is over, we would like to introduce you to the Quality Improvement and Patient Safety initiatives within the health system. House staff participation in these initiatives and projects are vital for our hospitals' efforts to bring the best care to patients, so we hope you will find this quarterly newsletter to be useful in your professional journeys. This issue of our newsletter highlights many exciting developments in the realm of Quality Improvement and Patient Safety including a series of trainee/faculty projects, information about Health Equity Advancement by Learners (HEAL), and more.

In this issue we are excited to share three quality improvement projects from residents across the system. We hope that you will read this and be inspired to improve something in your clinical areas.

For those who are interested in health equity, in this issue you can read about the opportunity to be involved with HEAL. This is great opportunity for those who wish to learn how to address healthcare inequities in patient care.

Lastly, we have included 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. As a reminder: SafetyNet 2.0 is available! Learn more about the new features on page 10. Thank you 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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UPCOMING MEETINGS

CLER Subcommittee Meeting
Wednesday, September 4, 2024 | 5:15-6:00 PM

Email GME@mssm.edu if you are interested in attending

Improving Colorectal Cancer Screening Completion Rates: A Quality Improvement Project at General Medical Associates at Mount Sinai Beth Israel

Mount Sinai Beth Israel
Courtesy of the *Department of Internal Medicine*
Mako Koseki, MD
June 2024

At GMA (General Medical Associates), the outpatient resident clinic at Mount Sinai Beth Israel, we launched an exciting resident-led initiative to raise awareness about colorectal cancer (CRC) and improve screening rates. The project was driven by a commitment to address disparities in CRC screening and ensure early detection, which is critical for effective treatment and improving patient outcomes.

We began by collaborating with the IT department to create a CRC screening dashboard using demographic information available from EPIC to perform our needs assessment. The initial CRC screening completion rate when we started the project was 64%. We found that CRC screening rates among individuals ages 45-49 had the lowest completion rate at 34% as compared to the highest completion rate of 73% in ages 65-69. Out of those who did complete screening in ages 45-49, 45% used Cologuard (stool DNA test) as a modality for screening, which is a higher percentage for use than all other age groups averaging 26%. Additionally, we found that the site primarily serving Medicare/Medicaid patients had a lower overall completion rate, but higher Cologuard use compared to the site primarily serving Commercial/Medicare patients. We did not find any disparities in screening between gender, race, and zip code of residence.

Given the changes that were happening to MSBI hospital and the closure of the colonoscopy suite, we decided to focus our QI project on the promotion of Cologuard use via patient and provider education to help bridge a potential screening gap during this time of change. We then implemented interventions using an iterative plan-do-study-act (PDSA) model among patients aged 45-75 at average risk of CRC. Interventions included provider education and patient awareness. Biweekly small lectures to the providers were taken in place to troubleshoot common patient barriers to Cologuard return, to go over procedural steps, and to inform the importance of CRC screening. We also distributed informative pamphlets in waiting and exam rooms to educate patients and prompt discussions during visits.

Our interventions led to a general increase in CRC screening rates and an improvement in Cologuard completion rates, especially among male and younger patients. The most recent post-intervention screening rate has been 68%, and completion rates of those ages 45-49 has improved to 39%. The Cologuard order and completion rate has slowly but consistently increased since the start of the intervention, reflecting the positive impact of our efforts.

Moving forward, we will continue to refine our interventions using the PDSA cycle, aiming to further enhance CRC screening completion rates. The insights gained from our data visualization efforts will guide ongoing education for providers and inform future strategies to reduce health disparities and improve patient outcomes in CRC prevention. We are grateful to all the preceptors, co-residents, and staff at our clinic, whose support and collaboration have been instrumental in driving this project forward.

Transitional Care Management Follow Up for Elderly Patients Admitted to Mount Sinai Hospital

The Mount Sinai Hospital

Courtesy of the *Department of Geriatrics and Palliative Medicine*

Geriatrics and Palliative Care Fellows 23-24: Grace Perez-Benzo, MD; Yu Shindo, MD; James Cescon, MD; Kristal Pouching, MD; Rodrigo Taniguchi, MD

Geriatrics Nurse Practitioners: Samantha Banker, MS, AGACNP-BC (MACE Geriatrics Inpatient); Danialle Coyne (ALIGN)

Geriatric Medicine Faculty Supervisors and Senior Coaches: Shahla Baharlou, MD; Fiorella Perez, MD; Martine Sanon, MD

July 2024

Hospital discharge of elderly adults can lead to errors in further care in the community such as medication reconciliation errors. The Centers for Medicare and Medicaid Services (CMS) has recognized the hazards of hospital discharges for older adults and instituted a reimbursable program targeted at hospital discharges referred to as Transitional Care Management (TCM). The necessary components to bill for TCM include an attempt to contact the patient within two business days of discharge and a follow up visit within 14 calendar days of discharge.**1**

Medicare instituted reimbursements for TCM in 2013. The payment model has increased the rate of primary care follow up after a transition of care, however, over half of eligible patients nationally still did not have primary care follow up after a transition of care, and only about one tenth of patients receive all the components that accompany the TCM reimbursement.**2**

On a local level, the Brookdale Department of Geriatrics and Palliative Medicine at Mount Sinai has two inpatient services: the Mobile Acute Care for the Elderly (MACE), which is the primary service for patients seen at the Martha Stewart Center for Living (MSCL) in the outpatient setting, and the Concurrent service, which is a consult service that follows those seen at MSCL who are admitted to other non-medicine services. A key component of geriatric inpatient care at Mount Sinai is facilitating transitions of care. The TCM workflow is supported by the ALIGN (Aging, Life Innovations, Goals & Needs) team, which is a high-risk clinic embedded in the MSCL geriatrics clinic that schedules TCM visits and supports TCM calls as needed.

A quality improvement (QI) project was conducted during the academic year of 2023 through 2024 by a group of geriatrics fellows with the hypothesis that patients who are discharged from the Concurrent service have a lower rate of TCM calls and follow up visits than those discharged from the MACE service. One of the primary reasons for this proposed discrepancy is that the geriatricians are not the primary team discharging the patients on the Concurrent service.

PLAN

Baseline data was collected and found that the post discharge call rate for those discharged from the Concurrent service was 86.9% compared to 85.5% on the MACE service. The difference between the two services was the post discharge follow up visit within 14 days where only 47% of those discharged from the Concurrent service attended a follow up in the allotted time compared with 85.6% of patients from the MACE service.

Two focus groups generated feedback around possible reasons for the lower follow up rate, which include lack of availability of the primary doctor for a follow up visit within 14 days, patient confusion when patients are scheduled with someone who is not their primary doctor for the follow up visit, and patient prioritization of specialty visits over primary care visits. Of note, many patients are scheduled with the ALIGN team for the TCM visit.

The aim of the QI project was to increase the post discharge follow up rate as measured by the actual completion of the post discharge follow up visit within 14 calendar days of discharge with the goal to increase the completion rate for patients discharged from the Concurrent service by 20% during the study period.

DO

The intervention included the following components: education for the geriatrics fellows on the TCM process, the scheduling of a follow up visit within 14 days of discharge prior to the post discharge telephone call in order to use the call to remind patients of the visit, and patient education about the importance of the TCM follow up as well as the possibility that it will be scheduled with the ALIGN team or another urgent provider other than their primary doctor. The final point was facilitated by the use of a dot phrase generated in the electronic medical record included in the discharge instructions.

STUDY

Measurements included the completion of TCM calls after appointment creation, dot phrase usage, and the TCM visit completion rate.

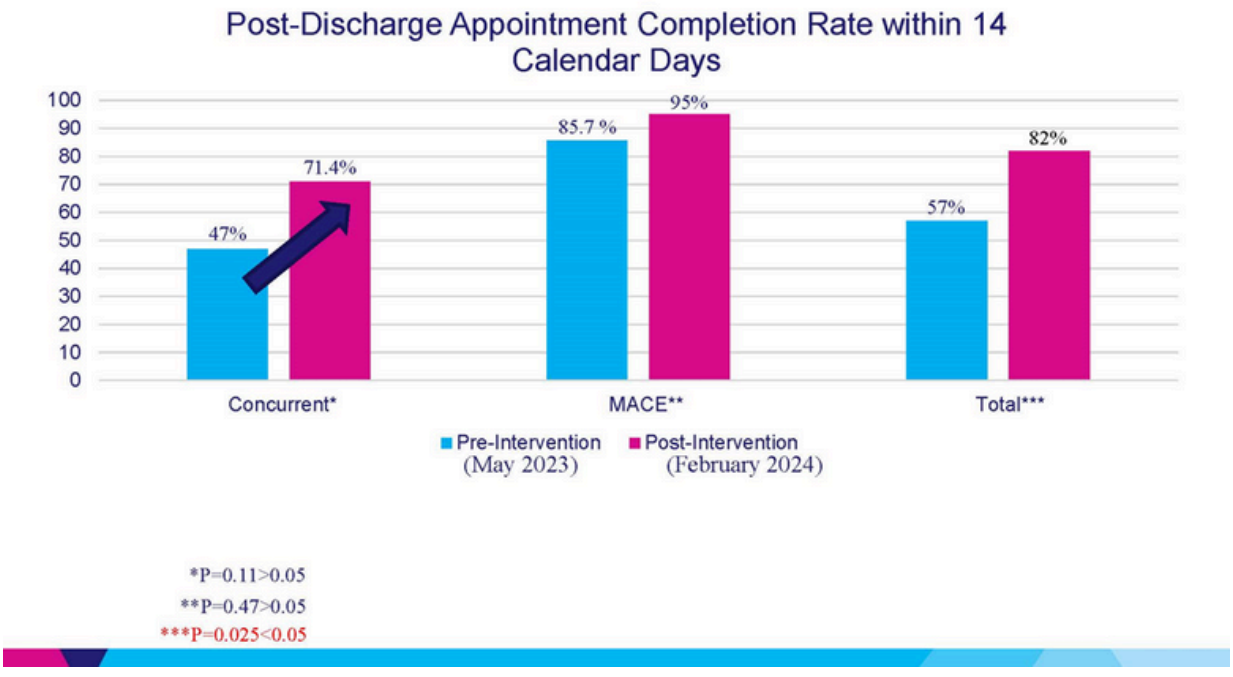
The post discharge completion rate within 14 calendar days increased from 47% to 71% among the patients admitted under the Concurrent service (the results were not statistically significant). The post discharge follow up appointments did not statistically change for the patients admitted to MACE, but the overall completion rate increased from 57% to 82%, which was statistically significant. The usage of the new dot phrase on the AVS occurred 23% of the time, and the completion rates for the TCM post discharge calls did not significantly change.

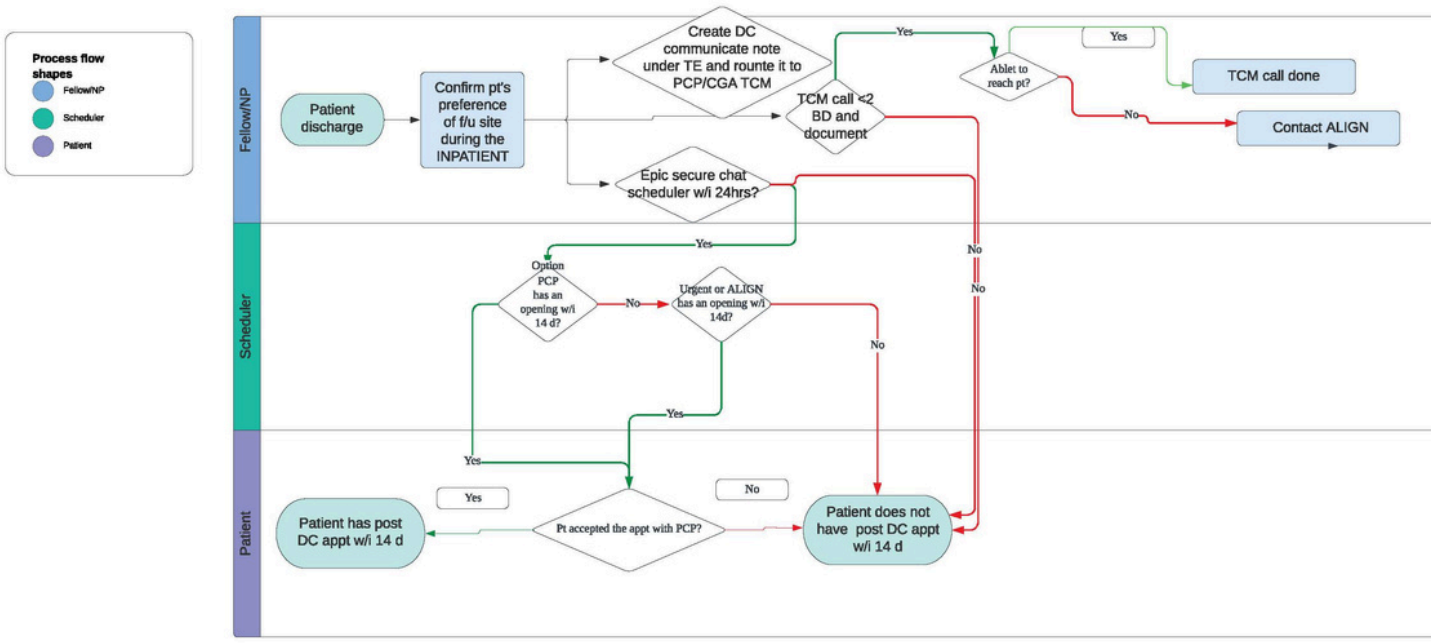
Upon further review, 50% of patients who missed their appointments missed the visits due to cancellations while about a third of visits were missed due to provider related tasks such as lack of completion of the post discharge call.

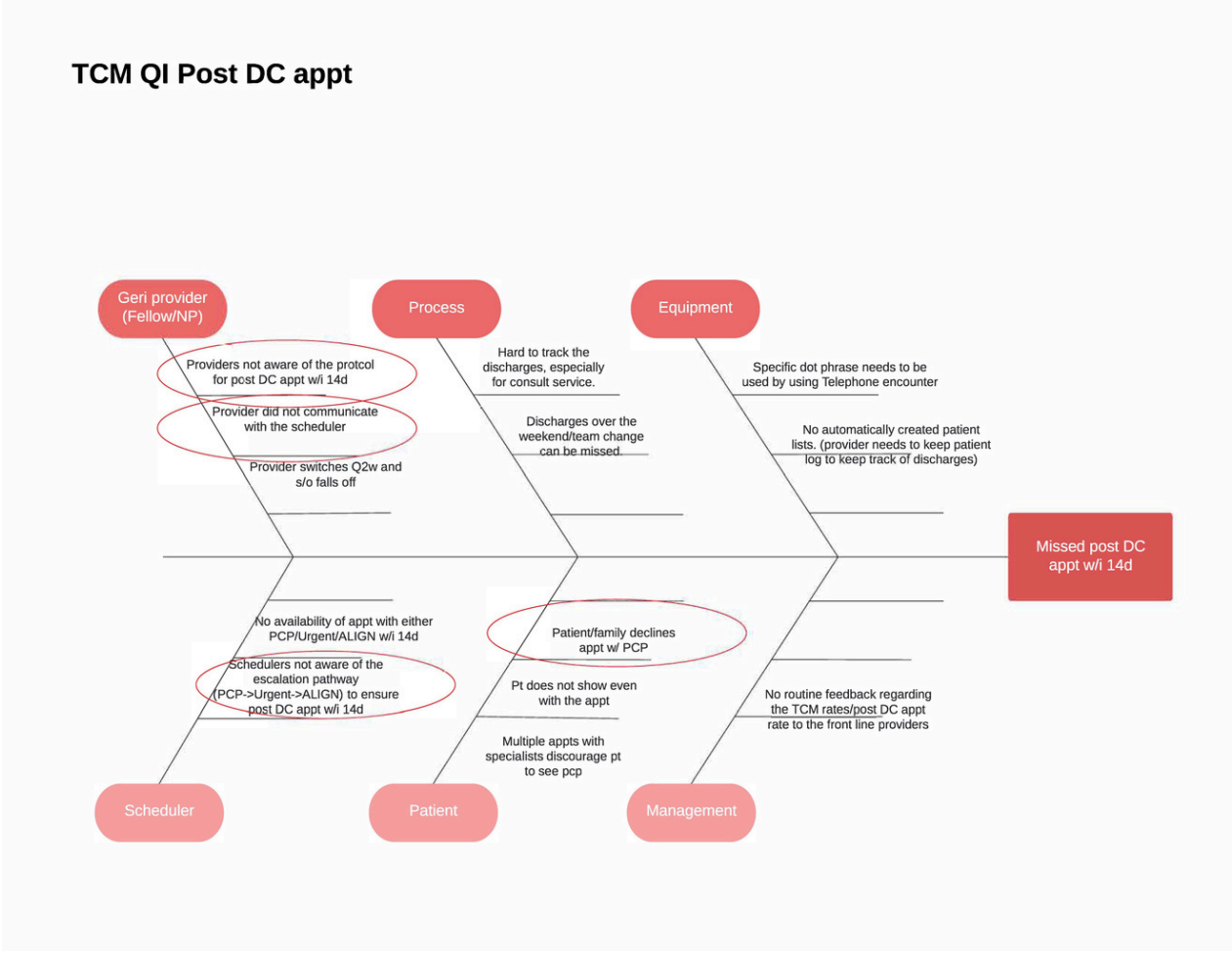
ACT

With an increased understanding of gaps in the transition of care process post hospital discharge from Mount Sinai Hospital, further interventions around patient education regarding the importance of close follow up as well as provider education around ways to help facilitate this follow up are needed.

Once it is determined how best to coordinate transitions of care post discharge from Mount Sinai Hospital, the next step is to standardize the process and incorporate into the discharge process of the geriatric patients at all Mount Sinai sites.





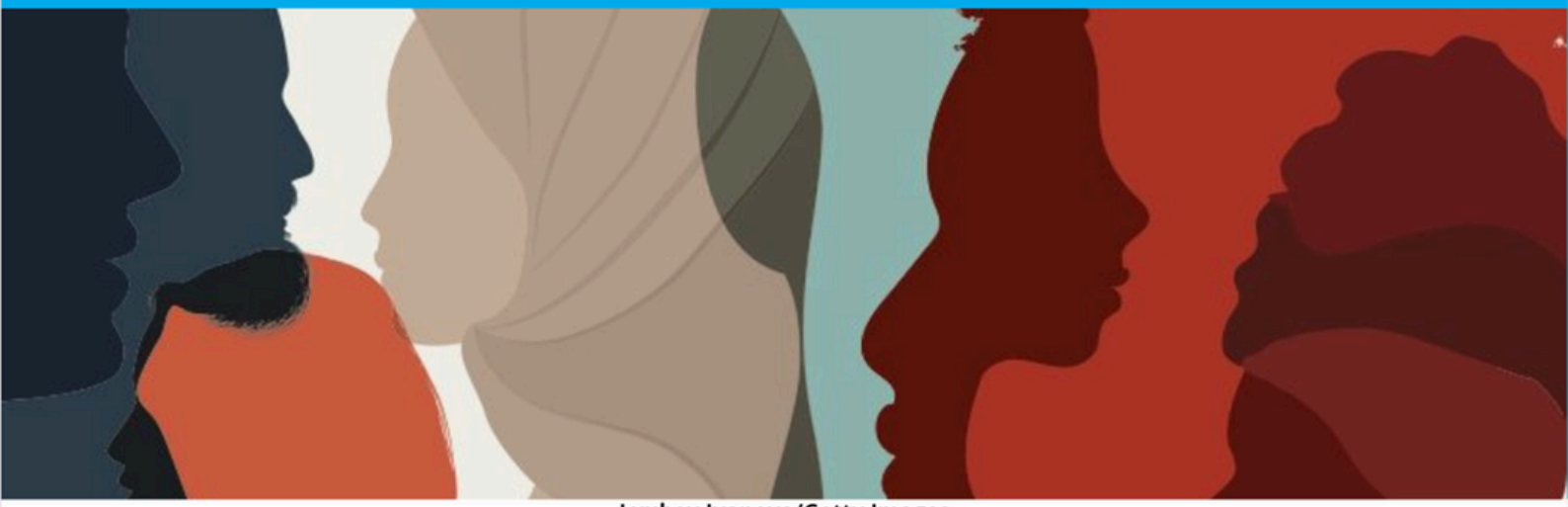


References

1. Rockafellow J, Edelen RB, Shen W Md P. Building a Financially Sustainable Transitional Care Management Workflow. Fam Pract Manag 2023;30(1):18-21
2. Anderson TS, Herzig SJ, Marcantonio ER, et al. Medicare Transitional Care Management Program and Changes in Timely Postdischarge Follow-Up. JAMA Health Forum 2024;5(4):e240417-e240417, doi:10.1001/jamahealthforum.2024.0417

HEALTH EQUITY ADVANCEMENT BY LEARNERS

Kenneth Ashley, MD
Angie Buttigieg, MD
Emily Hertzberg, MD, MS
Rui Jiang, MD, MPH
Betty Kolod, MD, MPH
Eric Kutscher, MD
Nicole Ramsey, MD, PhD
Jessica Reid-Adam, MD, MS
Paul Rosenfield, MD
Richard Silvera, MD, MPH
Barbara Warren, PsyD



Lyubov Ivanova/Getty Images

Healthcare disparities vs. healthcare inequities, what are the differences?
A disparity is defined as “a noticeable and usually significant difference or dissimilarity.” An inequity is defined as “an instance of injustice or unfairness.”

A health disparity is a “difference in health outcomes.” Meanwhile, health inequities are “injustices that result from systemic, avoidable, unfair, and unjust barriers, which create poor health.” Interested in learning more? Join HEAL!

Who are we?
We are a group of educators from across the Mount Sinai Health system, drawn together by our desires to learn more about and address healthcare disparities and health inequities. HEAL stands for Health Equity Advancement by Learners. Our mission is to provide learners with inspiration, connections, mentorship, an educational platform, and the tools they need to address the healthcare inequities in their clinical learning environments.

How does HEAL serve the GME community?
HEAL provides cultural humility education through experiential learning for residency and fellowship programs. Our goal is to equip faculty and learners with the skills and perspective to serve the diverse populations of NYC with compassion and professionalism. We also provide community and mentorship to trainees and faculty who are passionate about addressing the inequities that they see.

If you would like to bring our educational session to your training program, if you’d like to become an educator, or if you have questions, please email us at HEAL@mountsinai.org.

QI Med Ed Abstract from 2024 IME Education Research Day: Initiation of Oral Contraceptive Pills (OCPs) in a New York City Emergency Department

The Mount Sinai Hospital

Courtesy of the *Department of Emergency Medicine*

Paige Rattner, MD; Svetlana Duvidovich, DO; Monica Dragoman, MD; Rachel Solnick, MD; Morgan Bowling, DO

July 2024

Purpose and Goals: Across the country, high-quality, accessible family planning services have become increasingly difficult to obtain, particularly for underserved populations and young adults. Historically, contraception counseling and initiation occurs at either a primary care practice or at an outpatient family planning or gynecology office. However, the medical literature supports that patients are amenable to emergency department (ED) based contraception counseling and interventions. Our pilot program aims to 1) improve emergency medicine (EM) provider knowledge of contraception options and contraception counseling skills, 2) offer ED-based contraceptive counseling, and 3) initiate same-day oral contraception pills (OCPs) to eligible patients in the ED.

Methods: Implementation will include a two-pronged approach. The first is focused on education of EM providers on contraception counseling, including a didactic based curriculum on contraceptive options, methods for contraception counseling, identifying eligible patients for OCPs, and selection of OCPs. The second will focus on rollout, including developing and testing an on-shift 'OCP selection decision-tree.'

Evaluation Plan: First, EM providers will complete surveys before and after the didactic curriculum intervention to assess provider-satisfaction with the curriculum and perceived self-efficacy on ED-based contraceptive options, counseling, and OCP selection. Second, we will assess if the curriculum intervention leads to changes in clinical practice (e.g. increasing ED-based contraception counseling, initiation of OCPs in eligible patients, and referral for follow up, including for initiation of alternative methods of contraception).

Summary of Results: Development of the curriculum is ongoing. We hope to begin the intervention mid-2024.

Reflective Critique: Our primary objective is to improve EM provider knowledge of contraceptives to allow for safe, effective, and patient-focused expansion of contraception counseling and OCP initiation in the ED. We are implementing this project in a high-volume, NYC ED, which comes with time and capacity limitations. Our aim is to develop a streamlined process for EM providers, including targeted educational materials and in person training sessions, co-developed with our OB/GYN Complex Family Planning colleagues. It will also include an on-shift decision tree specifically for EM providers. Importantly, patients will receive contraceptive counseling on all FDA-approved contraceptives to ensure each patient is making an informed decision about their contraceptive needs. Patients receiving same-day OCPs will be provided with resources for outpatient follow-up and patients who express interest in alternative forms of contraception or additional counseling will be referred to outpatient OB/GYN or Family Medicine. As EDs become an increasingly important setting for preventative medicine and public health interventions, this focused innovation ensures EM providers have the knowledge and skills necessary to effectively and safely expand access to contraception for their patients.

Effective, safe, and affordable contraception can be difficult to obtain, particularly for high-risk patient populations. Emergency departments (ED), especially those across the Mount Sinai Health System, often serve as safety nets for a vast and diverse patient population. With many patients turning to our health system as their primary access to care, it is essential for ED providers to be comfortable with contraception counseling and initiation. Currently, there is no system-wide approved protocol for contraception counseling and initiation at Mount Sinai.

Therefore, the overarching aim for our quality improvement project is to implement such a protocol, and be able to offer contraception counseling and intervention to all patients presenting to an ED across the Mount Sinai Health System. We also hope that this work will demonstrate the feasibility and safety of providing ED-initiated contraception, eventually functioning as a blueprint for other EDs across the country to provide similar care.

As noted in our abstract above, we have initiated a pilot quality improvement project (QI). The specific aims of this pilot QI project are to: 1) improve EM provider knowledge of contraception options and contraception counseling skills, 2) offer ED-based contraceptive counseling to eligible ED patients, and 3) initiate same-day oral contraception (OCP) to eligible ED patients. While the end state target population and overarching aim is to include all patients presenting to the ED with the ability to get pregnant, the pilot project as noted above will focus on a smaller target population. This will allow for more targeted measures in the pilot phase, with hopes to expand in the near future.

To achieve our first specific aim (Improving EM provider knowledge of contraception options and contraception counseling skills), we have been working with our family planning colleagues to develop a succinct and efficient didactic curriculum to be taught to EM providers. To achieve our second and third specific aims, (Offering ED-based contraceptive counseling, as well as initiating same-day OCPs to eligible patients presenting to the ED), we have developed an evidence-based 'OCP Selection Decision-Tree'. This decision tree has been approved by the Mount Sinai Evidence-Based Practice Steering Committee, Mount Sinai ED System Quality & Safety committee, and is now pending final approval from ED leadership. Once approved, the decision tree, along with specific outpatient referral information, will be made available to all providers via Epic. This will allow providers to access and refer to these resources easily while on shift. Once these resources, as well as the provider education curriculum are implemented, we will begin to measure whether these efforts lead to increased ED-based contraception counseling, increased initiation of OCPs in eligible patients in the ED, as well as increased referrals from the ED for contraception related follow-up.

Doing QI as a trainee, both as a resident and a fellow, has been a very rewarding experience. While we are in the early phases of this project, we have already learned a great deal about the process of taking a QI project from the ideation phase to implementation. We have had the opportunity to step outside our clinical roles and to work with leadership across the health system to improve patient safety and healthcare delivery. As trainees, we are often hyper-focused on our clinical responsibilities; however, having the opportunity to help deliver more efficient and more equitable care to our patients through this QI initiative has not only given us a new perspective, but also helped inform the way we think about clinical care.

A big thank you to our mentor Dr. Morgan Bowling, and expertise of Dr. Monica Dragoman and Dr. Rachel Solnick. We are also immensely appreciative of the support we have received from the Mount Sinai Evidence-Based Practice Steering Committee and Mount Sinai ED System Quality & Safety committee. We are excited to continue our efforts and offer this essential care to our patients!

Quality improvement lessons learned from National Implementation of the "Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook".
Sullivan JL, Shin MH, Chan J, et al. Health Serv Res. 2024;Epub May 8.
Effective implementation of patient safety practices remains an organizational challenge. This qualitative study explored lessons learned and opportunities for improvement based on nationwide implementation of the VA Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook aimed at standardizing patient safety practices in the Veterans' Affairs (VA) Community Care Network. Researchers conducted semi-structured interviews with patient safety officers, quality managers, and community care staff, and identified barriers and facilitators to Guidebook implementation (e.g., resource availability, organizational culture). Qualitative findings underscored the importance of leadership engagement, role clarity, and effective communication.

Building a resilient patient safety culture: a large healthcare organization's approach to systematically reviewing serious harm events.
Harvey B, Dhalla IA, O'Neill C, et al. Healthc Q. 2024;27(1):19-25.
Error reporting and analysis is a key element of a learning organization. This article describes one healthcare organization's approach to systematic review of serious harm events through use of a standardized classification system, frequent meetings, inclusion of the patient and family voice, and application of human factors strategies.

A human right-based approach to dealing with adverse events in residential care facilities.
McGrane N, Behan L, Keyes LM. Health Hum Rights. 2024;26(1):115-128.
Many regulatory authorities require notification of adverse events involving vulnerable individuals, such as those in care facilities. In this study, almost 200 statutory notifications from residential care facilities (RCF; e.g., nursing homes, assisted living) were analyzed to ensure residents' human rights (fairness, respect, equality, dignity, and autonomy) were upheld during adverse events. In the majority of adverse events and their management, residents' human rights were upheld.

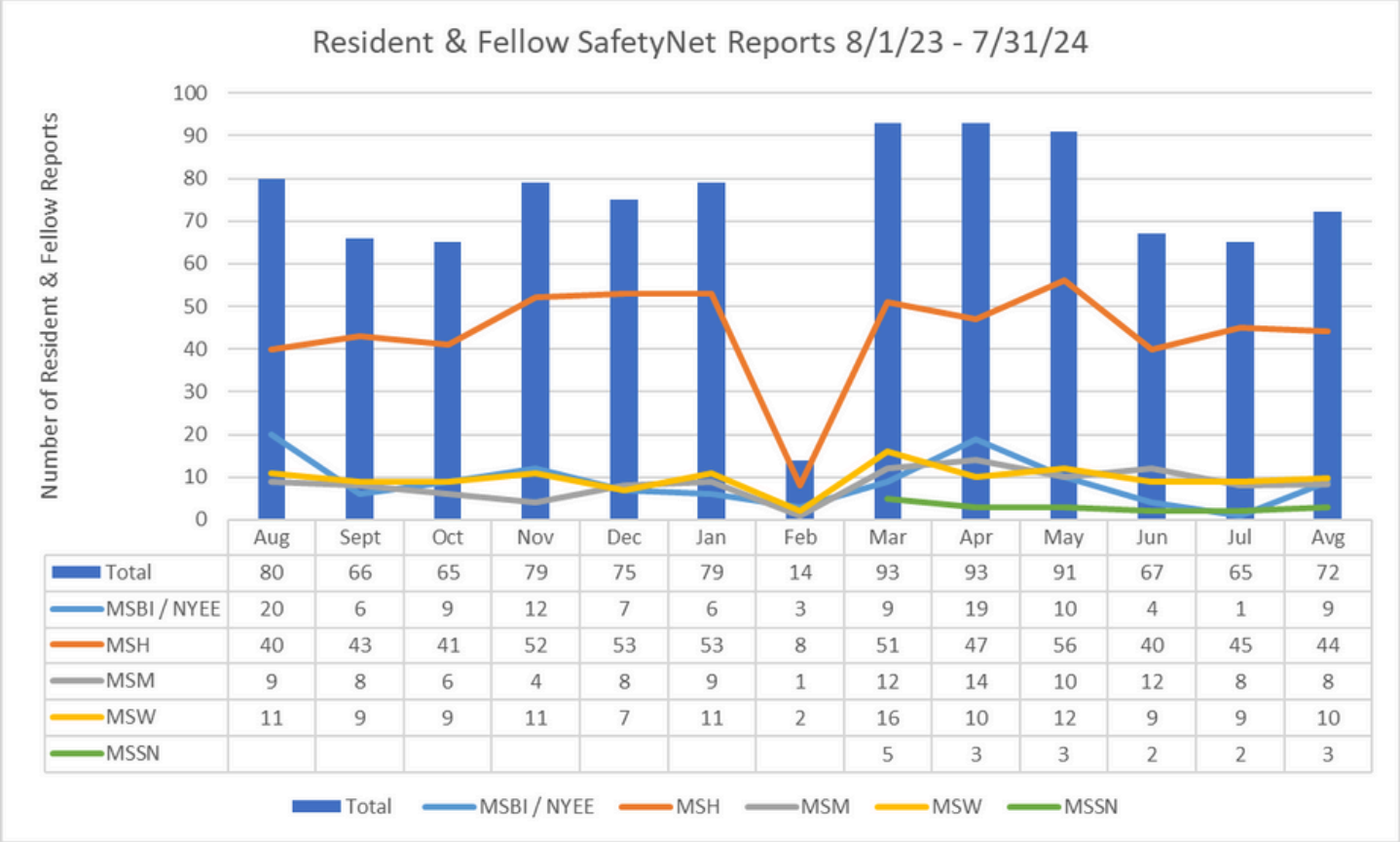
A multifaceted risk management program to improve the reporting rate of patient safety incidents in primary care: a cluster-randomised controlled trial.
Chaneliere M, Buchet-Poyau K, Keriel-Gascou M, et al. BMC Prim Care. 2024;25(1):244.
Voluntary incident reporting remains low despite its demonstrated importance in improving patient safety. This randomized controlled trial tested the impact of a multidisciplinary effort to increase event reporting in primary care settings. The intervention included e-learning training modules, identification of a risk management advisor, and multidisciplinary meetings focused on patient safety incidents at each facility. Only 7 of the 17 facilities fully implemented the program, and there were no improvements in reporting rates in intervention or control facilities.

To improve health care, focus on fixing systems - not people.
Mate KS, Clark J, Salvon-Harman J. Harvard Business Review. July 12, 2024
While a focus on the systems approach is a long-standing element of patient safety improvement, organizations are still challenged to fully adopt this concept. This commentary describes elements of a care operating system designed to support patient safety and worker well-being through the design of processes that generate excellence, transparency, and reliability.

SafetyNet

Below you will find SafetyNet resident and fellow reporting statistics for the 12-month period August 1, 2023 - July 31, 2024. Since the last issue of this newsletter, the average number of total reports across sites decreased to 72. April 2024 totals exceeded the average for the year. February 2024 is an outlier with only 14 total reports. The significant decrease in reports in February 2024 could be attributed to the updated SafetyNet platform. Since 2020, the percentage of SafetyNet reports entered by residents and fellows has been steadily increasing, however we have a system-wide goal of seeing at least 5% of all SafetyNet reports as being entered from residents and fellows. Please keep on that same trajectory and continue to report in SafetyNet!

SafetyNet 2.0 is available! Click here to learn more about new features and training. 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.



	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Avg
Total	80	66	65	79	75	79	14	93	93	91	67	65	72
MSBI / NYEE	20	6	9	12	7	6	3	9	19	10	4	1	9
MSH	40	43	41	52	53	53	8	51	47	56	40	45	44
MSM	9	8	6	4	8	9	1	12	14	10	12	8	8
MSW	11	9	9	11	7	11	2	16	10	12	9	9	10
MSSN								5	3	3	2	2	3

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.