GME QUALITY IMPROVEMENT AND PATIENT SAFETY NEWSLETTER

MESSAGE FROM THE GME ASSOCIATE DEANS FOR QI & PS

Dear MSHS Residents, Fellows and Faculty,

As we approach the end of 2024, we would like to wish everyone a safe and joyous holiday season! Your continued efforts to implement and support Quality Improvement and Patient Safety projects are vital for our hospitals' efforts to bring the best care to patients. This issue of our newsletter highlights many exciting developments in the realm of Quality Improvement and Patient Safety including an overview of the FAIR Initiative, another installment in our Clinical Command Center (CCC) series, and more.

In this issue we are excited to share a brief guide about Front-line Provider Sign on. We hope that you will read this and be inspired to improve something in your clinical areas.

Additionally, we've included the new residents members of the 2024-2025 Root Cause Analysis (RCA) Committees, which are part of the Serious Adverse Event Process for Patient Safety. Participating members of the RCA Committees are provided with orientation and training, and are invited to attend at least eight (8) RCA meetings over the course of the academic year, providing input to case discussions and safety solution meetings.

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 9. 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, December 18, 2024 | 5:15-6:00 PM

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

Front-Line Provider (FLP) Sign on Tip Sheet

The Mount Sinai Hospital
Sandeep Gangadharan, MD, First Year Healthcare Administration, Leadership and Management (HALM) Fellow
Associate Professor, Pediatrics
September 2024

FLP Situation, Background, Assessment, and Recommendation (SBAR)

Attribution of Staff to Patients at MSH

Situation

- Currently many patients and service lines do not attribute which clinicians are caring for a patient at a given time point
- **Ensuring the correct attending** is identifiable and assigned in Epic 24/7 if critical for medicolegal purposes and for escalation of patient care needs.
- **Ensuring a front-line line clinician** is identifiable and assigned in Epic 24/7 is critical to ensure timely communication and a responsive, in-house staff member for patient care needs
  - **Ensuring a primary provider team** is assigned allows for staff to escalate needs. Ideally FLP, residents would be assigned within the provider team as escalation pathways

Background

- Epic Secure Chat is increasingly used for communication with front line clinicians.
- **This makes direct, in Epic, attribution of physicians to each patient critical.**
- Our system allows for attribution within a feature called Provider Teams.
- An Attending, Front line clinician, resident, APP can be assigned and attached to a patient for a specified shift/time interval. Nursing already signs into each patient assignment in this manner.
- Allows for individual messaging and escalation to a resident versus attending if need be.
- If no FLP is assigned and ONLY an attending is assigned, nursing, lab, radiology and other ancillary services have no choice but to Epic Chat the attending who may not be in house.
  - **Identifying a standard designator and protocol for the first call clinician for every patient in the hospital is essential for safety, effective teamwork and communication.** Identifying escalation pathways (i.e., second call, attending) is essential as well.
  - **An essential component of the FLP sign in is that an accurate contact number be provided as well in the initial sign-on screen. If that is done once, it need not be changed and any process of sign in to a treatment team will work fine.**

Assessment

56% (n=275) of all resident/fellow sign ins and 28% (n=77) for APP/NP/PA across Medicine and Pediatrics
Goal is 100%

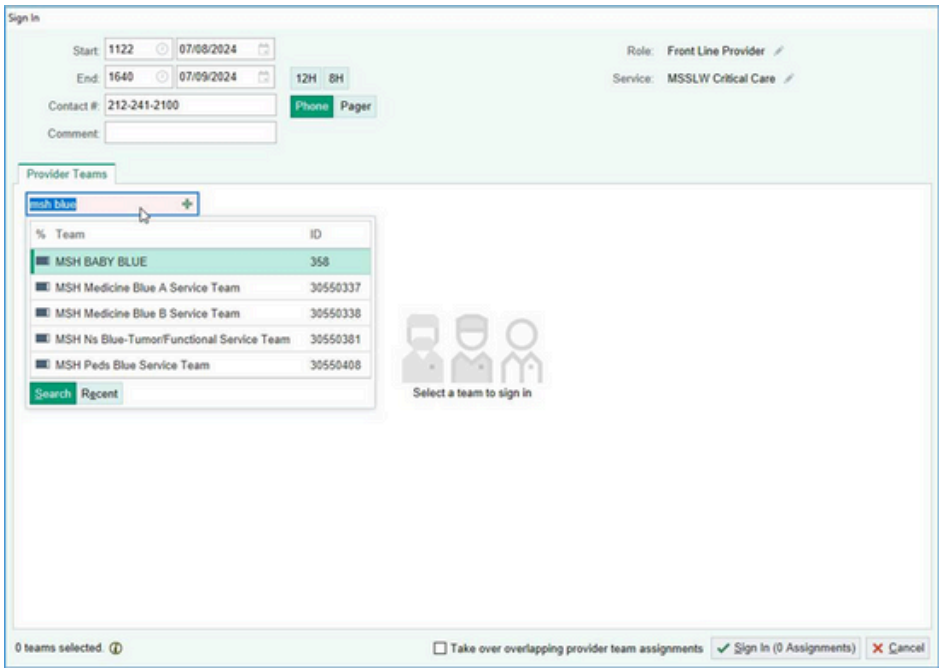
Recommendation

- See below to learn how to designate yourself as the front-line provider.

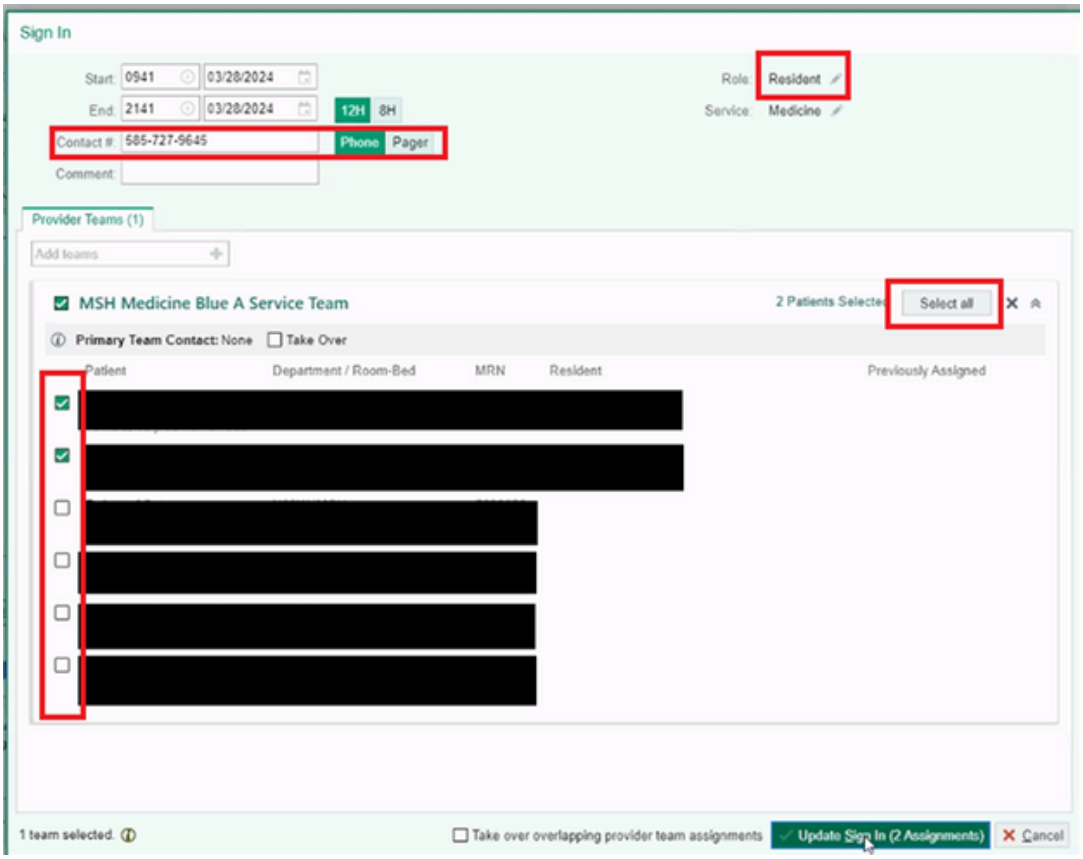
Reliable identification of front-line providers is an essential safety tool in ensuring the timely, safe effective care of patients admitted to a hospital. Physicians, nurses and staff need to know exactly how to reach the providers who are responsible for the care of the patient at all times. Services such as the laboratory and radiology, among many others, may need to communicate directly with the front-line provider to convey a critical result or for clarification. The Mount Sinai Hospital is committed to ensuring that this important safety tool is a standard operating procedure for all front-line clinicians and asks each FLP to ensure that their primary contact number and assigned treatment teams/patients are confirmed at the start of each clinical shift. Please see the instructions below for how best to sign on via EPIC.

Workflow

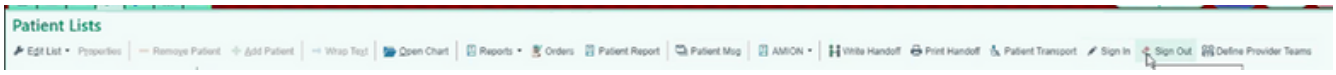
1. Log into Epic
2. Pop up to sign-in appears as shown below. This will appear anytime you are not signed in (i.e., if you are working from home writing notes, chart reviewing, or are not actively caring for patients, the pop up will still appear. You may click cancel if you are not on shift and caring for patients).



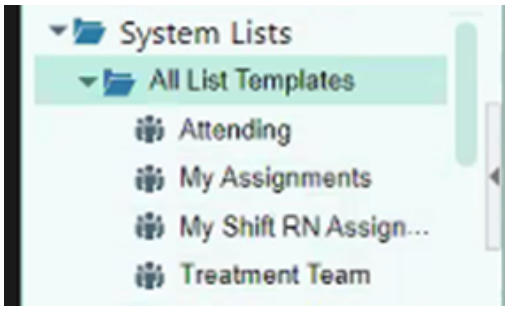
3. The Provider Teams tab should be selected as below.
   - Update your time on shift indicating the Start and End times
   - Update your contact information to the appropriate phone number you will use for communication on
   - shift. This phone number will remain while you are signed in on shift and remain populated during future sign-ins unless removed. **We strongly suggest using a Sinai sponsored cell phone or pager here.**
     - You may add a comment (i.e., if you wish to be called for RRTs, Codes directly on this phone number)
   - Update your role either as Front Line Provider, or Resident
   - Under “Provider Teams,” add your current team name.
   - Select the patients you will care for during your shift.
     - You may select all as well. This will select every patient on a given provider team versus select the patients individually (this will allow you to sign into part of the provider team).



4. Once you do so, your name will appear listed nested under the provider team rather than as an isolated treatment team member with the appropriate contact information listed as sign-in phone.
5. In order to end your assignment, you can click sign out and it will sign you out of all your patients in one go. (Note: If you enter an “End” time, you will be automatically signed out at that time.)



6. The “My assignments” patient list will pull in the patients for whom you are listed as a member of a provider team. This is a great way to ensure when you are off shift, no patients are listed under your name.



7. Once a team is signed in (Resident and FLP), clinicians can contact your entire team using Secure Chat. This feature will aid laboratory, radiology and ancillary service lines communicate effectively with the whole team. As always, you may leave chats that are not relevant to you.

The Central Psychiatrist Program at the Clinical Command Center (CCC)

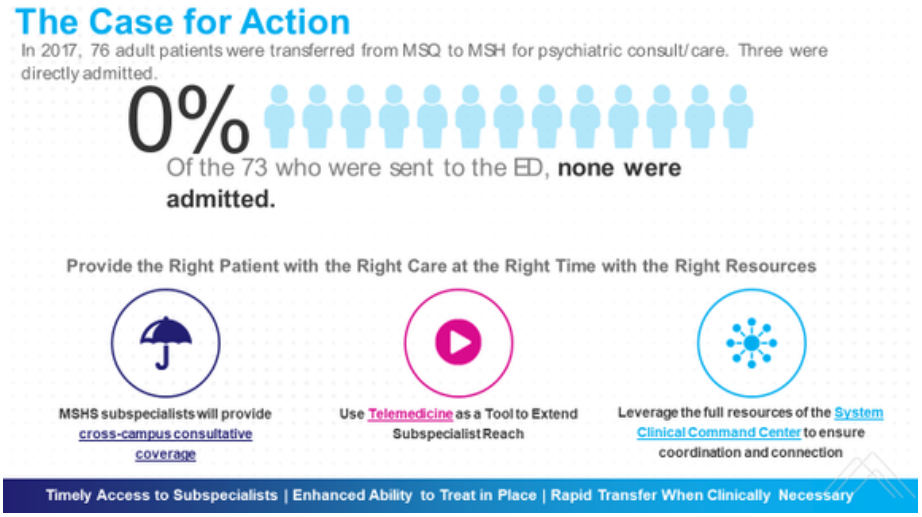
Icahn School of Medicine at Mount Sinai
Courtesy of the *Clinical Command Center*
Barbara Barnett, MD, MS, FACEP, FACP, Chief Medical Officer of the CCC, System Vice President for Throughput
Jennifer Siller, DNP, ACNP - BC, NEA - BC, Vice President, Clinical Operations, Mount Sinai Health System
Kevin Chason, DO, Associate Professor, Emergency Medicine, Mount Sinai Hospital
October 2024

On July 15, 2024 the Department of Psychiatry and the Clinical Command Center launched the Central Psychiatrist program. The Central Psychiatrist joins the Central Intensivist and Central Hospitalist as the third central role that was implemented to help improve access to care for patients within and outside our health system. The idea for a Central Psychiatry model was first realized in 2017 when a review of 76 patients who were transferred from the MSQ ED to the MSH psychiatric ED for a psychiatric consult found that only three of these patients were admitted for psychiatric care. The remaining 73 were all discharged following their psych evaluation after two emergency department visits and a transfer via ambulance. As a result of these findings, coverage models for tele-psych consults in the MSQ and MSB ED were established as well as and the tele-consult workflow.

The model for tele-psychiatry and its effectiveness have been well established with first use noted in 1959 at the Nebraska Psychiatric institute to conduct remote therapy groups, provide consults and train medical students. Prior to COVID, the Mount Sinai Health System had invested in creating a telehealth network using the Teledoc platform. Devices that could be brought to the patient bedside, with pan tilt and zoom capability, along with the ability to connect peripheral devices like stethoscopes were deployed to all ED's and ICU's. Smaller cart mounted iPads were deployed to all of the inpatient units. The process to request stat consults is coordinated through the health system's command center.

Working with the psychiatry department and central on call coverage model was developed to serve all the emergency departments without onsite psychiatry services. Using Epic, a provider can place an order to request a tele-consult. All tele-consult orders placed for patients in the Emergency Department default as a STAT order which generates an alert to the Clinical Command Center's Logistic Team. The covering psychiatrist is contacted and connected to the requesting provider. The telemedicine device is moved to the patient location and the consulting provider is able to evaluate the patient with secure two-way audio and video connection.

The overall time to complete a consult has been effectively reduced. The need for transfer has been significantly reduced and while not directly measured to date the patient satisfaction anecdotally is improved. The role of the central psychiatrist also involves the coordination of behavioral health transfers from outside hospitals and between our health system hospitals. This process has standardized the practice of transferring behavioral health patients. The process started with creating a policy to describe the process to evaluate, identify risk for violence and elopement, coordinate with security, EMS and health care teams the safe transportation of this patient population. Additionally, the policy clarifies the documentation, including the legal documents that are needed for voluntary and involuntary behavioral health patients. The transfer process using the central psychiatrist has reduced the time to assess patients for transfer, identifies patients at high risk to the patient care team and ensures all documentation is reviewed prior to transfer.



Promoting Factual, Affirming, Informative and Respectful (FAIR) Documentation in Electronic Health Records (EHRs) to Reduce Bias and Improve Patient Care

Mount Sinai Health System

Courtesy of the *Office of the Chief Medical Officer and Institute for Health Equity Research (IHER)*

Allison Glasser BSPT, MBA; Daphnée Hyppolite, MPA, RHIA; Lynne D. Richardson, MD, FACEP; Carol R. Horowitz, MD, MPH; Rebecca Anderson, MPH

October 2024

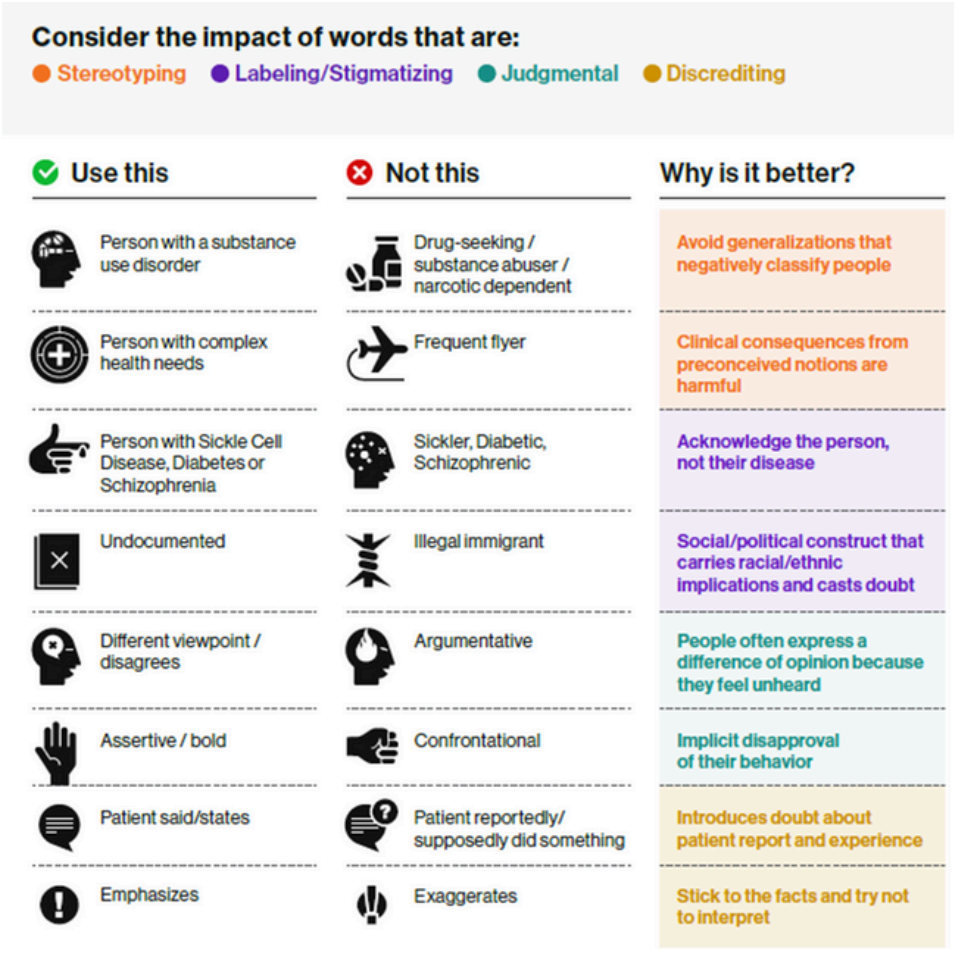
Mount Sinai has an ongoing commitment to advancing health equity and the FAIR Initiative aims to promote the use of Factual, Affirming, Informative, and Respectful language in all interactions with our patients to foster a culture of respect and inclusion at MSHS.

Why is FAIR documentation important?

- FAIR and affirming language improves quality and patient safety, by reducing the risk of bias. It also supports better health outcomes and enhances clinician-patient relationships, communication and trust.
- Negative terms and language can be stigmatizing and reinforces harmful stereotypes. This can impact a patient's mental health and well-being and bias clinicians to view patients more negatively than others.
- Patients and other clinicians read your notes! The 21st Century Cures Act provides patients access to all of their medical records. We are all patients and if you do not want to see it in your chart, it should not be in someone else's chart.

We all have difficult days and often document after hours, when tired & rushed. Before documenting, pause and consider your intention and impact. Ask yourself:

- How would I feel if I saw these words in my chart? My family's chart?
- Is this information relevant to the patient's clinical care?
- How will my patient feel when they read my note?
- How might what I wrote impact our relationship?



To learn more about the FAIR Initiative visit the intranet site. It includes resources and tools on how to write in a FAIR manner, links to presentations about FAIR documentation, and reference materials.

2024-2025 RCA Committee Members - New Residents and Fellows

Welcome to the new residents members of the Hospital RCA Committees for the 2024-2025 academic year! We are excited for them to join the network of physicians who continue to improve quality and patient safety!

Ahmed Ayad, MBBCh
Pathology, Anatomic and Clinical Pathology
MSMW

Shasha Chen, DO
Pulmonary Disease and Critical Care Medicine
MSMW

Jared Dashevsky, MD
Internal Medicine
MSH

Nirmit Desai, MD
Pulmonary Disease and Critical Care Medicine
MSH

Svetlana Duvidovich, MD
Pediatric Emergency Medicine
MSH

Marta Dzyadyk, MD
Critical Care Medicine
MSH

Howard Freeman, MD
Pulmonary Disease and Critical Care Medicine
MSMW

Emily Gore, MD
Internal Medicine
MSH

William He, MD
Internal Medicine
MSMW

Annum Jaffer, MD
Pediatric Hospital Medicine
MSH

Dhara Kadakia, MD, MA
Obstetrics and Gynecology
MSMW

Janhawi Kelkar, MD
Anesthesiology
MSH

Madison Kennedy, MD
Internal Medicine
MSMW

Michael Le, MD
Anesthesiology
MSH

Christine Lenchur, DO
Internal Medicine
MSMW

Christina Lewis, MD, MSc
Neonatal Perinatal Medicine
MSH

Neil Makhijani, MD
Emergency Medicine
MSMW

Alyson Meyer, DO
Internal Medicine
MSMW

Patricia Miguez Arosemena, MD
Internal Medicine
MSMW

Mudassir Mumtaz, MD
Diagnostic Radiology
MSMW

Kristen Pacific, MD
Anesthesiology
MSMW

Swati Patel, MD
Internal Medicine
MSMW

Natalie Plick, MD
Internal Medicine
MSH

Jackson Runte, MD
Emergency Medicine
MSH

Caileen Sennett, MD
Internal Medicine
MSMW

Melanie Simons, MD
Pediatrics
MSH

Allison Wang, MD
Gastroenterology
MSMW

Artificial intelligence-powered chatbots in search engines: a cross-sectional study on the quality and risks of drug information for patients.
Andrikyan W, Sametinger SM, Kosfeld F, et al. BMJ Qual Saf. 2024;Epub Oct 1.
Patients frequently use the internet, and now chatbots, to learn more about their health, symptoms, or medications. This study queried Microsoft's Bing chatbot, Copilot, about the 50 most frequently prescribed and over-the-counter medications. Drug.com's patient information was used for the reference database. Mean completeness was 76.7%, and mean accuracy was 88.7%. Experts evaluated a subset of 20 questions and found approximately half aligned with scientific consensus.

From reporting to improving: how root cause analysis in teams shape patient safety culture.
Tsamasiotis C, Fiard G, Bouzat P, et al. Risk Manag Healthc Policy. 2024;17:1847-1858.
Morbidity and Mortality Conferences (MMCs) and Experience Feedback Committees (EFCs) are two strategies to support individual and organizational learning from adverse events. This study, conducted at one French hospital, examined whether MMCs and EFCs improve patient safety culture among healthcare professionals. Findings suggest that participation in MMCs and EFCs improves certain aspects of safety culture (error response, organizational learning), but systemic challenges, such as staffing and leadership support, hinder widespread improvements.

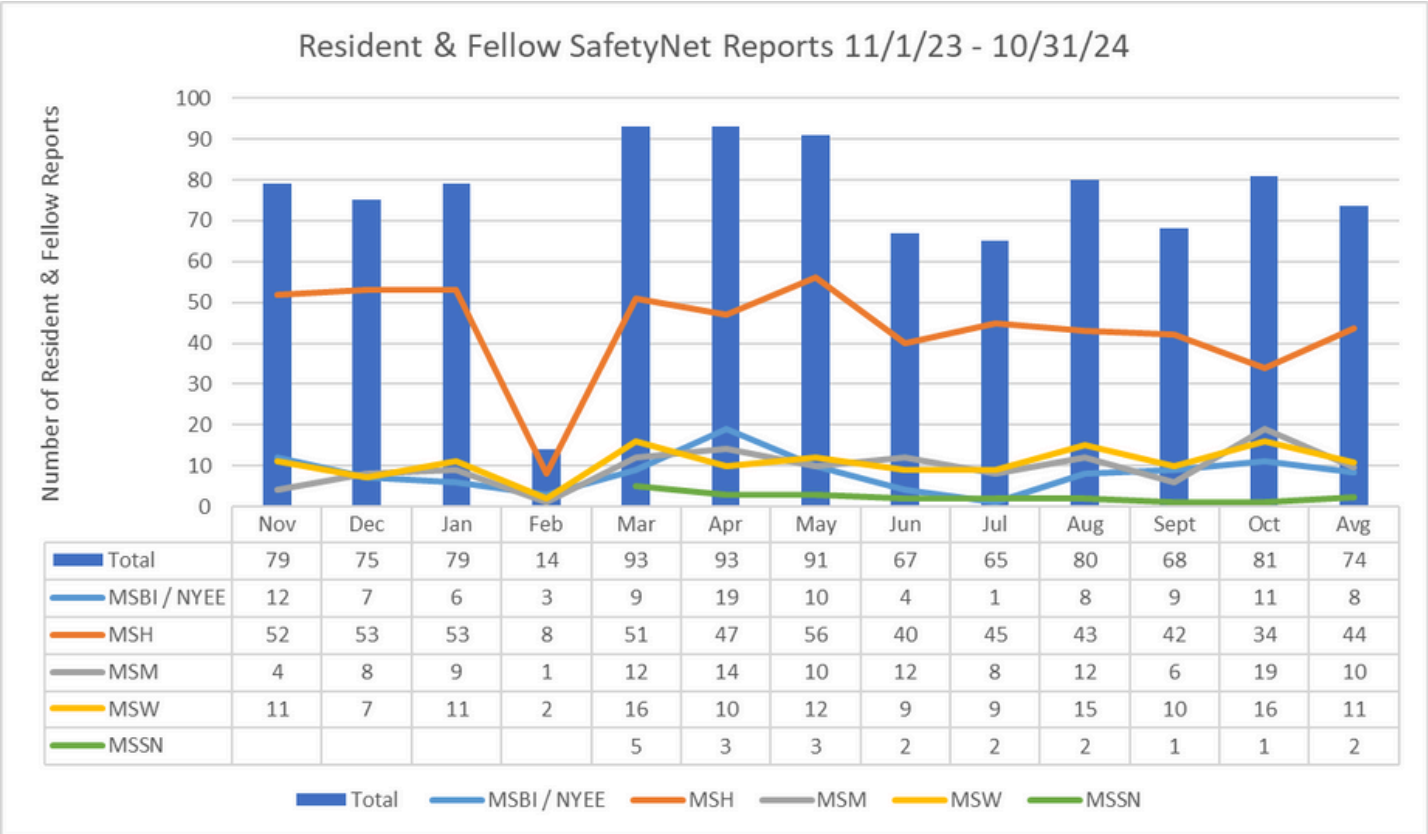
Medicine communication from hospital to residential aged care facilities: a cross-sectional survey of aged care facility staff.
Browning S, Raleigh RA, Hattingh HL. *Int J Clin Pharm.* 2024;Epub Sep 30.
Transitions of care present challenges, such as loss of information or misunderstandings, that can negatively impact patient safety. This study explored how residential aged care facilities (RACF) manage medications when residents enter the facility from a hospital. The authors state that a resident discharged from the hospital to RACF ideally receives a supply of new or changed medications, a hard copy of a discharge summary, an interim medication administration record (IMAR), and, if discharged from the ED, an Emergency Department Discharge Medication Administration Record. Responses from 31 RACF demonstrated these practices vary widely, with less than half always receiving an IMAR and one-third always receiving a hard copy of the discharge summary.

From theory to policy in resilient health care: policy recommendations and lessons learnt from the Resilience in Healthcare Research Program.
Wiig S, Lyng HB, Guise V, et al. *J Patient Saf.* 2024;20(7):e109-e114.
Resilient healthcare organizations can effectively adapt to challenges and changes while delivering safe, high quality patient care. The Resilience in Healthcare (RiH) Research Program is a large-scale, multi-country study of resilience and adaptive capacity across different healthcare settings (i.e., hospitals, nursing homes, home care). In this paper, the authors share lessons learned and highlight several recommendations for policymakers to improve resilience in health care, including the role of patients and caregivers, creating a culture of collaborative learning, and the importance of relational leadership.

SafetyNet

Below you will find SafetyNet resident and fellow reporting statistics for the 12-month period November 1, 2023 - October 31, 2024. Since the last issue of this newsletter, the average number of total reports across sites increased to 74. March and 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.



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Avg
Total	79	75	79	14	93	93	91	67	65	80	68	81	74
MSBI / NYEE	12	7	6	3	9	19	10	4	1	8	9	11	8
MSH	52	53	53	8	51	47	56	40	45	43	42	34	44
MSM	4	8	9	1	12	14	10	12	8	12	6	19	10
MSW	11	7	11	2	16	10	12	9	9	15	10	16	11
MSSN					5	3	3	2	2	2	1	1	2

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.