Medical Staff Orientation

Huntington Hospital – NSLIJ Health System

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CONTENTS

Section I – Background Page

Role of the Medical Staff in Improving Healthcare Quality 4

Patient safety: what is it all about? 4

Using measurements to understand unintended variation, identify opportunities and assess the effectiveness of efforts to improve care 5

Section II – Hot topics for Physicians

Physicians-of-record, consultants, coordination and continuity 6

Improving Surgical Outcomes by Standardizing Work 7

Team functioning and clinical outcomes 8

Hofstra – NSLIJ School of Medicine 9
Dear Colleague,

Huntington Hospital/NSLIJ is at a crossroads. We are providing a greater depth and diversity of clinical services than ever before...Bariatric surgery, coronary intervention, electrophysiology, joint replacement, intracranial neurosurgery, neonatology, robotic surgery, spine care, traumatology and more. Additionally, we are being recognized for excellence more than ever before, by way of the ANCC Magnet designation for nursing, Joint Commission Certification of Excellence for Hip and Knee Replacement Surgery, and Joint Commission Certification for Palliative Medicine among others. We were the top community hospital in the metro region for the past two years as reported by US News. Perhaps most notably, we have sustained a risk-adjusted hospital mortality rate that is among the lowest in our region.

The challenges, however, are daunting. Our national healthcare system is at risk of collapse. Healthcare costs are rising at an unsustainable pace, even as many physicians face declining reimbursement. We spend a far larger fraction of our GDP on healthcare than any other developed nation, but insure fewer individuals than our comparators and score far from the best across a range of quality measures. National leaders, therefore, are demanding that we think about healthcare delivery in dramatically different ways. A new term, “the value equation” is heard everywhere. And these demands are now translating into new and very unfamiliar ways to measure and reimburse the clinical work of physicians and hospitals. Where in the past we were compensated for clinical activity, in the near future we will be compensated for outcomes. To be successful we will need to focus more than ever on reducing healthcare-associated harm, improving care coordination across settings, providing excellent end-of-life care, and reducing waste.

In the midst of uncertainty, there are two things we know: first, that we either create boldly or become irrelevant, and second, that our medical staff must help lead this kind of transformative change. Even more fundamentally, we recognize that meeting these challenges is our ethical responsibility as physicians individually, and as an organization collectively. Together, we have the opportunity to build the kind of healthcare we will want for ourselves and our loved ones.

Welcome to our medical staff and to the North Shore LIJ Health System! You will find colleagues who are focused on excellence and on building upon the great tradition of our profession. These are also individuals who comprise a closely knit community of professional fellowship. Huntington’s medical staff members are exceptionally generous of spirit and mutually supportive. We look forward to your contributions and your ideas. And speaking on my own behalf, please don’t hesitate to call, email or stop by my office at any time.

Kind regards,

Michael B Grosso, MD, FAAP
Role of the Medical Staff in Improving Healthcare Quality

In the past decade, three transformations in our thinking about healthcare have challenged us as practicing physicians. The first was the realization that healthcare-associated harm was more common and more preventable than we had ever thought. The second was that a startling lack of standardization has limited the effectiveness of our healthcare system. And most recently, a body of research has exposed the problem of “overuse”: care that does not appear to improve clinical outcomes, but does expose patients to potential harm and create a drain on our limited resources.

Physicians at our hospital and across the North Shore LIJ Health System play a crucial role in providing leadership, creativity, expertise and initiative to a host of efforts aimed at making healthcare safer, more effective, more efficient and, critically, more patient-centered. These individuals understand that we need to collaborate across specialties and disciplines to engage in the hard work of redesigning how we deliver care. We need to think differently about what we do if we are to become better than we are. In the current environment, this is not only an ethical mandate but a prerequisite for survival.

Patient safety: what is it all about?

The term “patient safety” describes at once a problem in healthcare, a framework for understanding that problem, a social movement, and an academic discipline. The “problem” is avoidable harm that arises not from the patient’s condition, but from our care. It is now clear that such harm is much commoner than once believed, and that entering a hospital is among the most hazardous acts most ordinary persons experience. Avoidable infections affect 96,000 Americans annually. Medication events affect almost as many, killing 6,000. Wrong patient and wrong procedure mishaps, and “failure to rescue” occurrences are reported from almost every institution, large and small.

Many health professionals misunderstand what experts tell us about the causation of errors and harm, assuming that the message is “don’t make mistakes.” Neither the concept of “negligence” nor that of “incompetence” appears in the core message of patient safety. This is not because we don’t need effective, committed caregivers. We have never needed them more. The point is that we already have the best professional workforce in the world, but errors and harm keep happening anyway.

In fact, a key precept is that there is a limit to what any one physician or nurse can do on her own to make healthcare safer. This is because safety is a characteristic of systems. You can admonish drivers not to have accidents, or...
you can install antilock brakes. You can instruct nurses not to administer concentrated potassium, or you can sequester the potassium in the Pharmacy. Designers of safety systems anticipate inevitable human errors, and then put measures in place to prevent them or mitigate their effects. (Some safety systems can be circumvented by professionals who regard them as unnecessary or inefficient. Organizations that have a safety culture react to simple human error with support for the caregiver; such events are unfortunate but ethically neutral. The right question is WHAT, not WHO went wrong. By contrast, willful violations of appropriate safety rules – unless circumvented to meet an emergent need – are always unacceptable.)

Patient safety overlaps significantly with other dimensions of healthcare quality, such as effectiveness (using the best science), efficiency (avoiding interventions not known to add value), timeliness (providing the right care at the right time) and patient centeredness (sharing decisions with patients and families, and partnering with them to ensure the best care during and after hospitalization).

In an environment where limiting harm and cost are both priorities, the relationship between safety and efficiency deserves mention. Not only is there a great deal of waste in our system that can be eliminated without adversely affecting safety. Additionally, work by a number of investigators suggests that “overuse” may actually drive down quality, exposing patients to harm associated with unnecessary tests and treatments while also negatively impacting patient experience of care (Davis and Schoen, 2007). Accordingly, efforts to improve safety and efficiency are seen by many experts not as competing priorities, but as essentially synergistic. The ABIM Foundation’s Choosing Wisely Campaign is perhaps the most ambitious effort to date, drawing on more than 60 collaborating organizations to identify opportunities to achieve better quality by doing less.

**Using performance measurements to understand unexpected variation in practice, identify improvement opportunities and assess the effectiveness of quality initiatives**

Performance measurement in healthcare remains an imperfect science. But there are strong reasons for us to understand the measurements that are now used by many stakeholders to measure and report on our performance – hospitals, CMS, the Joint Commission, the Department of Health, insurance companies, governmental and private stakeholders, and the press. Beyond this and despite various caveats, a number of measurements have proven their worth in helping us to improve care.

A full discussion of measurements and their use is beyond the scope of this short orientation. Here is a short primer:

- **Process measurements** describe the fraction of the time that an appropriate action occurs in relation to opportunities for it to occur. Examples include the fraction of patients with acute coronary syndrome and without a contraindication who receive aspirin during the first 24 hours of their hospital stay.
- **Outcome measures** describe the “results” of care, often as negative results – e.g. death, infection or other complications such as DVT or PE.
- **Measurements** can also be classified as informing us about different dimensions of performance, such as **safety** (measuring preventable harm), **timeliness** (e.g. door to balloon time for coronary interventions), **efficacy** (adherence to guidelines), **efficiency** (length of stay, resource utilization) and **patient-centeredness** (patient experience of care measures).
Measurements are used throughout our hospital to better understand our strengths and weaknesses, the results of quality improvement efforts and possible opportunity areas. “Measure sets” have been created, validated and implemented by many regulators and private quality improvement groups. For example, we track measures for pneumonia, surgical care, myocardial infarction, heart failure, stroke and pediatric asthma; infection rates for MRSA, VRE, and C. difficile; rates of central line bacteremia, catheter-associated UTI, ventilator associated pneumonia and surgical site infections. We also monitor a host of measures for patient experience and satisfaction. This is a partial list. Most measures are publicly reported, and some drive hospital reimbursement through the federal Value Based Purchasing program. Oversight for our work to improve performance comes from various quality committees, your Medical Board and the hospital’s governing body (Board of Directors).

**Physicians-of-record, consultants, coordination and continuity of care**

An important responsibility of the physician of record is to oversee actively the activities of any consultant that he has requested to participate in his patient’s care. This begins with thoughtful consideration to the reason for any consultation. We have consultants for every organ system – merely having a condition that resides within a subspecialty scope of practice is NOT an indication for consultation. Rather, the physician of record should seek consultation when diagnosis or management are outside his scope of practice, or in question, or when a consultant is required to perform a procedure.

Second, the physician seeking consultation should communicate personally with the consultant to identify the issues (this is required for urgent consults but strongly advised for all.) An end-point for the consultation should be identified.

Third, the physician of record is obligated to provide ongoing care coordination with her consultants. For example, Mrs. Jones is being managed by a general internist, who has sought Pulmonary and Infectious Disease consultations. A nurse calls the primary physician to report that the patient has new onset tachypnea. Among the wrong responses is “Call the pulmonologist.” It is the primary physicians’ responsibility to get all of the relevant information either on the phone or at the bedside, determine the problem, and THEN if necessary call the consultant personally. Having nurses serve as a go-between for the medical staff is not a recipe for high quality care.

The physician-of-record’s daily notes should include the findings of consultants, and in discussions with family he should direct his best efforts to communicating a comprehensive explanation of the patient’s condition and treatment plan, inclusive of those issues addressed by his consultants. Not addressing these responsibilities results in poorly coordinated care, lesser quality and more errors. Inevitably, there is also a loss of confidence on the part of patients and families left to wonder “who is in charge of my care?” Doing this well, on the other hand, is a hallmark of effective, patient-centered care.
**Check a box, save a life:**

**Improving Surgical Outcomes by Standardizing Care**

Surgical judgment and technical skills contribute to favorable outcomes. So do standardizing care and implementing checklists. This was the conclusion of a multisite study by Gawande et al published in the New England Journal of Medicine (N Engl J Med 2009; 360:491-499; January 29, 2009). The investigators compared perioperative complications and mortality among 7600 patients, half of whom received care in centers following the introduction of a surgical safety checklist. The intervention group experienced a third fewer complications. Mortality in the control group was twice as high as among patients receiving surgical care with the checklist implemented.

The Huntington Hospital Surgical Care Improvement Project (SCIP) Steering Committee has implemented the WHO Surgical Safety Checklist as one of a number of protocols to address preventable adverse events such as perioperative infection, venous thromboembolic events, wrong patient/procedure/site occurrences, and operative delay due to improper equipment, instruments, drugs or devices. The checklist has been implemented across all surgical services of the NSLIJ Health System. Other examples of improvement through standardized practice follow.

- **Standardized antimicrobial prophylaxis** for many procedures, based on evidence and consensus-based guidelines as communicated by CMS through the national SCIP quality improvement initiative.

- **Preoperative antimicrobial administration and timing** is in the purview of the anesthesiologist. For most agents, the requirement is administration within 60 minutes prior to incision.

- **Post-operative antimicrobial timing** also conforms to national guidelines by protocol. Perioperative order sets ensure that post-operative prophylaxis is discontinued within 24 hours of surgery. If the surgeon identifies the need for continued antimicrobial treatment beyond the period required for prophylaxis (i.e., greater than 24 hours post-operatively) an indication must be written in the chart.

- The anesthesiologist must administer an appropriate beta blocker to patients on chronic beta blockade, OR document that it was administered prior to arrival in the Operating Room on the day of surgery OR document the contraindication.

- **Peri-operative VTE prophylaxis** includes mechanical and pharmacological strategies based on expert guidelines and risk. Protocols have been implemented across all surgical services.
Clinical Outcomes as a Function of Team Effectiveness: Team STEPPS

A provocative study from the world of pediatric critical care identified a statistically-significant, inverse relationship between the rates of central line bacteremia across various units and the number of physicians and nurses in the units who used first names on a regular basis.

Analysis of severe adverse outcomes -- like operation on the wrong patient or delayed intervention in the deteriorating patient -- identifies time and again the role of communication. In fact, the Joint Commission’s database of “Sentinel” events demonstrates that communication problems were contributory in full two thirds of cases.

Cardiac surgeons know how important the team is. Safety experts believe that much the same is true in the ED, the Delivery Room and many other environments where health professionals interact. Recently, there has been interest in adapting team expertise from other high risk industries to healthcare. Few of us trained in teams, though this is now changing. Key issues include effective communication among team members, an unfettered exchange of ideas and mechanisms that “stop the line” when a team member believes that an unsafe condition exists. (Click here for comments by patient safety expert and surgeon Lucien Leape on teamwork and medical error.)

Team STEPPS is a program developed by the Agency for Healthcare Research and Quality in collaboration with the Department of Defense and other stakeholders. Building on principles adapted from aviation and the military, TS equips members of healthcare teams with the skills and tools necessary to maximize coordination of care through effective teamwork. All physicians credentialed at NSLIJ hospitals should complete the Team STEPPS curriculum.

Our Code of Professional Conduct...

Your medical board has approved a CODE which describes our commitment as physicians and other professionals to HONESTY and integrity, patient confidentiality, RESPECT for staff, patients and families, RESPONSIBILITY for our patients, and CLINICAL EXCELLENCE achieved through lifelong learning and participation in quality improvement.

At the same time, we commit to strictly avoiding DISRUPTIVE behavior, including any behavior that could reasonably viewed as demeaning or intimidating, including profane or disrespectful language, verbal or physical outbursts, criticism of staff in front of patients or other staff and the like.

Such behaviors negatively impact recruitment, retention, and staff well-being. Critically, disruptive behavior negatively impacts communication and patient safety.

(See: Code of Professional Conduct, Medical Board Policy)
In 2006 the Association of American Medical Colleges, citing population increases, a doubling of the number of citizens over the age of 65 between 2000 and 2030, and an aging physician workforce, recommended that medical school enrollment be increased by 30% by 2015. Concurrently, Hofstra University and the NSLIJ Health System each had reached a rapid-growth stage of development at which collaborating to develop a nationally renowned medical school became a highly attractive and advantageous endeavor.

Thus began Hofstra Med, our Health System’s own medical school and the region’s first new school in four decades. Founded on principles of community, scholarship, innovation, professionalism, patient-centeredness, humanism and the vision of Dr. Lawrence Smith, a past member of the Huntington medical staff, the School of Medicine opened its doors in August 2011.

Huntington is one of several System hospitals to host first year students in the Introductory Clinical Experience, part of a program known as Patient, Professional and Society. Community preceptors in Medicine, Surgery, Obstetrics, and Pediatrics are partnering with students in a learner-centered program that creates synergy between the Basic Sciences and the bedside from the first weeks onward.

Other Huntington physicians are devoting their energy and expertise to medical education as faculty in the Structure Lab (once known as Anatomy!), in interactive case-based sessions and in our simulation center with standardized patients mentoring students on history taking and physical examination. Initial appointments to the School of Medicine are typically at the Assistant Professor level.

HUNTINGTON PHYSICIANS AND HOFSTRA MED STUDENTS: ONE ON ONE LEARNING

More than sixty preceptors are interacting with MS1 and MS2 students as part of the Introductory Clinical Experience (ICE). Building on work at Harvard, Case Western and elsewhere, students learn in an environment in which continuity is the organizing principle…continuity of site, of mentorship and of patients and families. Patients benefit from the extra attention from a long-term partner in their care. Preceptors derive professional and personal satisfaction from learning new skills and observing the long-term growth of their students.

Telling our stories...
Narrative Medicine at Hofstra Med

“Illness is the night-side of life, a more onerous citizenship,” writes Susan Sontag. Narrative Medicine acknowledges and moves beyond the limitations of the patient’s “history” to invite exploration of the story, that is, the experience of illness.

At the same time, Narrative work creates opportunities for the caregivers themselves to express and share the profound experience of working so intimately with fellow human beings who are suffering.

Medical educators have long been aware of the erosive effects of a “hidden curriculum” which results in a gradual blunting of empathic capacity among trainees. Narrative is widely viewed as a corrective to this erosive process.

Hofstra students and their faculty will engage in ongoing journaling to promote reflection and encourage personal growth. Its relationship to so many values of this new school places Narrative at the very heart of the curriculum.

Hofstra University -- North Shore LIJ School of Medicine

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