The surgical program at The Mount Sinai Medical Center and Mount Sinai School of Medicine is a lot of things in one. Like all academic medical programs, the medical center focuses on continuing excellence in training, research, and clinical care. Consistently ranked among the nation's best in a variety of disciplines, Mount Sinai is focusing much of its attention on understanding and testing some commonly held beliefs and time-honored practices in surgical care.

Take, for example, the focus on surgical checklists. Borrowed from the airline industry and given popular attention by author and Harvard physician Atul Gawande, MD, checklists and preoperative surgical timeouts have been shown to reduce errors. However, if checklists become so routine, a timeout becomes a "tune out." David L. Reich, MD, chair of anesthesiology at Mount Sinai, says his organization is working to make sure that never happens.

"The whole problem is, you can have a checklist, but to actually get people in the trenches, so to speak, to internalize these as a valuable part of their job experience is a bigger challenge," Reich says. "We don't just make our leaders talk about it; we're really working on the culture at the level of the people who are involved." Mount Sinai is one of eight medical centers participating in the Joint Commission's Center for Transforming Healthcare's Wrong Site Surgery Project, which is scheduled to release a toolkit this fall for preventing wrong site surgery. Some of the issues identified in the project relate to timeouts, such as when the timeout occurs before the staff is ready or when staff is rushed or distracted.

Reich says the research is focusing on refinement. "The initial challenges with timeouts included making the proper markings on the patient or following the scripts," Reich says. "Now we've learned that we have to really do several timeouts. We're now doing
a timeout before we do an anesthesia block because we learned we have to. We're pretty much discovering that we also need a timeout when we identify a surgical level, such as for spine surgery. So we're discovering that it isn't one timeout and one checklist; there needs to be many timeouts and many checklists."

The goal is to take the checklists—in Six Sigma terms—to "industrial levels" of safety, Reich says. "That is a tough standard to achieve. We can't just implement it and say we are great. It's about internalizing the processes and accepting their value."

Beyond checklists and timeouts, much of the current research in anesthesiology is focused on the data and procedures that influence surgical outcomes. Mount Sinai is participating in a study with Cleveland Clinic to understand how two key surgical measures—blood pressure and a depth of anesthesia calculation—affect patient outcomes. Anesthesiologists have generally believed that if a patient is “stable” by those two measures during surgery, their outcomes are fine. By analyzing data on 45,000 patients, the research looks at how a combination of the two could lead to complications later, Reich says.

The idea is to put some science into some commonly held beliefs about "normal" surgery by analyzing data on 45,000 patients.

“What’s ‘normal’ during surgery?” Reich says. "Normal during surgery is relatively low blood pressure. Surgeons like that because [patients] don’t bleed as much. But perhaps the blood pressure is lower than is good for the patient. The reason we need to do this research is to find out whether or not a stable blood pressure, which is low and which we previously accepted as normal, is in the best interest of the patient."

The New York patient

Mount Sinai is subject to the intense competition within New York City for patients and surgeons. One of the perhaps unique facets of the physician-patient relationship in New York City is that patients in New York tend to be more loyal to their physicians than to institutions. That relationship weighs on everything from patient satisfaction to physician compensation. For example, Evan Flatow, MD, chair of orthopaedics at Mount Sinai, and a renowned shoulder specialist, observes that “in New York people are very concerned that they have the best surgeon.”

As a result, "If a surgeon leaves a program, they’ll tend to take 80% of their practice with them," Flatow added. Patients may "sometimes be willing to put up with things like waiting in the office, but they don’t want to feel that they’re not going to the right person."

Even considering such loyalties, Mount Sinai has worked to improve the patient experience. In 2010, Mount Sinai opened
a new Joint Replacement Center, a 5,000-square-foot-floor that includes the Samuel and Ethel LeFrak Center for Patient Education. The center features HDTV monitors for video presentations on joint replacement as well as a computer bank for knee and hip education, safety, and rehabilitation. Mount Sinai has also begun patient education programs such as spine and joint schools, which allow patients scheduled for procedures to come 10 to 15 days in advance to see the facility and talk with nurses, social workers, and therapists.

“These do not replace physician-patient discussions, but they augment them powerfully because sometimes patients feel embarrassed to ask simple questions like how do they get to the bathroom after surgery,” Flatow says. “They feel embarrassed asking that in the OR.”

The Mount Sinai Medical Center is one of eight hospitals nationwide participating in the Wrong Site Surgery Project, initiated by the Joint Commission Center for Transforming Healthcare and the Lifespan system in Rhode Island. The goal of the project is to improve the safeguards to prevent patients from wrong site, wrong side and wrong patient surgical procedures. Other study sites include AnMed Health, Center for Health Ambulatory Surgery Center, Holy Spirit Hospital, La Veta Surgical Center, Lifespan-Rhode Island Hospital, Seven Hills Surgery Center and Thomas Jefferson University Hospital. Below are selected causes for wrong site surgery and suggested solutions identified in the project.

Source: The Joint Commission Center for Transforming Healthcare, The Wrong Site Surgery Project
physician’s office, but when they’re there with the floor nurse, these kinds of things come up, and it can be very reassuring to them to understand how it’s managed.”

The team has also taken multidisciplinary rounds to the patient, so to speak. In addition to the usual huddles where the team meets to go over patient issues, Flatow regularly joins colleagues including the heads of nursing, food services, social work, and housekeeping to walk the surgical floors and interview patients about their experience. Simple questions about how the food was or whether they had to wait in transport can lead to vital feedback, Flatow says. “I found that extremely helpful because a lot of that gets lost in the noise and the statistical aggregation of the typical quality measures. But when a patient says to you, ‘This was outrageous; just last night I was waiting two hours for someone to answer the buzzer,’ sometimes you’ll find a smoking gun immediately. You’ll find out last night there was someone on who’s been complained about before, and then we can move quickly to correct the problem.”

**New alignment, new role**

Mount Sinai has a history of inter-department collegiality and cooperation, says Michael L. Marin, MD, chair of surgery. So turf wars that may exist in other hospitals when technology throws two specialties together—such as vascular surgeons and interventional radiologists—have been relatively non-existent at Mount Sinai, Marin adds. That allows the health system to react to the market, creating centers and other subspecialty, multidisciplinary services that can attract patients and increase volume. The hospital developed a spine program a few years ago, and in November a brand-new center will open on a single floor and combine the orthopedists and neurologists.

Michael McCarry, RN, senior vice president of perioperative services at Mount Sinai, says the quaternary academic medical center has strengths in many specific areas, such as liver transplant, cardiac transplant, cardiac catheterization, and Crohn’s disease. The hospital is growing areas such as spine, ENT, and certain cancers such as colon and head and neck. “So our plan is to grow complex surgeries that sort of belong in a tertiary referral medical center,” McCarry says.

Mount Sinai is not immune to the reimbursement and physician alignment challenges that affect all hospitals in the switch from volume-based reimbursement to outcomes and quality, and is investigating and modeling how that will work. For now, Marin says, the evolution of the relationship shows up in areas such as more selective choices of technology, for example, due to a mutual interest in effectiveness and cost.

“The paradigm has shifted where we have a much more financially responsible approach to the use of technology,” Marin says. “We actually look at new ideas that physicians want to explore and carefully ask, ‘Does it really have an asset potential for the patients?’ And then we can define whether or not there is an economic impact, adversely or otherwise, on the hospital. So we now walk into the use of new technology with much greater knowledge and, I would say, a more careful forethought than we have ever in the history of surgery in modern times.”

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