Welcome to the 2nd Edition of UNM’s Quality Improvement Journal, and what an exciting time it is for resident physicians to be involved in quality improvement initiatives at the Health Sciences Center. More than ever before, residents are encouraged to bring forth their ideas to improve patient care. Having trained at UNM as a medical student and resident it is wonderful to see the medical community, both at UNM and nationwide, transition from quality assurance activities to include those centered around quality improvement. As a medical student and resident most of the quality activities I was involved in were mainly devoted to deconstruction of poor outcomes of individual patients often initiated through a sentinel event, complication or near miss. While I agree that case reviews are necessary and important for educational purposes, they often are limited in their scope and application to larger patient populations. If M&M sessions are not conducted in a safe and collegial manner, then providers involved in a poor outcome may be discouraged from submitting a complication for open review. Quality improvement holds great promise in supplementing our practice of sentinel event review with improved practice methods and patterns that can be applied to a large number of patients and providers.

I highly encourage residents to become aware of their own specialties’ efforts in safety and quality improvement for ideas that can be translated locally. The specialty of anesthesiology of which I am a member has made great strides in reducing the incidence of mortality related to anesthesia care, and the specialty has become a model for quality improvement methods. Anesthesia-mortality risk has declined from approximately 100 deaths in 100,000 anesthetics in the 1940s to near 0.8 deaths per 100,000 anesthetics today\(^1\). The drop in mortality has corresponded in a drop in malpractice insurance rates as well. Anesthesiologists pay less now for insurance than 20 years ago\(^2\). The specialty of anesthesiology has invested heavily in patient safety and quality improvement research. The American Society of Anesthesiology Closed Claims Project, begun in 1985, compiles and catalogs all malpractice claims against anesthesiologists in the United States with an emphasis on identifying trends in adverse outcomes. Also founded in 1985 was the Anesthesia Patient Safety Foundation, which at the time was one of the first patient safety organizations to use a multidisciplinary approach among providers, device manufacturers and medical specialties. Anesthesia-related morbidity, though, remains stubbornly high and significant efforts are underway to reduce this.

Efforts are also being made to study the effects of anesthesia well beyond the immediate perioperative period. Current initiatives include: reduction of awareness under anesthesia, elimination of operating room fires, post-operative visual loss registry, neurologic loss after non-spine surgery registry and reduction of medication errors. More recently, the American Society of Anesthesiology created the Anesthesia Quality Institute, which maintains the National Anesthesia Clinical Outcomes Registry (with the goal of being the central repository for all anesthesia case data in the United States), as well as the Anesthesia Incident Reporting System, which acts as a national database of all serious adverse events and near misses in the nation.

Within each of our fields are specialty and sub-specialty organizations dedicated to the improvement of patient care through the development and dissemination of practice guidelines, statements, standards and parameters. These guidelines are designed to assist physicians in

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making the best evidence-based decisions with their patients. It is quite common for faculty to rely upon residents and fellows to help tailor and implement clinical guidelines for the end-user. I draw our reader’s attention to an entry in this journal written by Dr. Katie Reyes as an example. Katie helped incorporate a recent guideline published by the Society for Ambulatory Anesthesia on obstructive sleep apnea (OSA) into local practice at UNM’s Outpatient Surgery Center (OSIS). This project involved development of a screening tool, creation of patient instructional material and reeducation of pre-anesthesia nursing staff. We anticipate that by using Katie’s screening tool we can avoid costly cancellation and hospital admissions related to undiagnosed OSA at OSIS.

Before concluding I would like to draw residents’ attention to another avenue for quality improvement projects: the electronic medical record (EMR). The University Hospital has taken tremendous strides to transition all patient charting to the EMR. Today most inpatient encounters are almost entirely electronic, and eventually all encounters will be. The key advantage of the EMR over paper charting (in the quality improvement realm) lies in the ability to carry out detailed searches of patient information within a matter of seconds. Provided that appropriate IRB and HIPPA boundaries are kept, a limitless number of questions can be asked and analyzed for systemic issues involving process and outcome.

Residents hold the future for medicine and improving the quality of medical care in the United States. I applaud this edition’s authors and challenge more residents to get involved in QI. This can mean joining your department’s QI committee, or not. A simpler step may just be studying your own work environment: there are likely many quality improvement projects lurking right under your own nose.

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