**Board Meeting
January 16, 2020**

2018 Annual Quality and Patient Safety Report

The Quality and Patient Safety program at the University of Illinois Hospital & Health Sciences System ("UI Health") supports quality and safety improvement for UI Health's entire scope of clinical operations including our hospital, clinics, and Mile Square Health Centers.

We also continue to partner and collaborate with UIC health sciences colleges and to pursue opportunities to align and integrate key quality and safety endeavors with other organizational priorities. Key 2019 highlights are briefly outlined below.

Quality & Patient Safety Division

Directed by UI Health's Associate Vice Chancellor for Quality & Patient Safety and Chief Quality Officer, the Quality & Patient Safety division comprises six teams:
- Accreditation & Clinical Compliance
- Clinical Documentation Improvement
- Health Information Management and Privacy Office
- Infection Prevention & Control
- Patient Safety & Risk Management, and
- Quality Performance & Improvement.

These teams work closely together to optimize alignment of activities and the magnitude of collective impact.

Quality & Safety Strategy & Leadership Steering Committee

Established in early 2013, the Quality & Safety Strategy & Leadership Steering Committee ("QSSL") continues to provide leadership, direction, and oversight to UI Health's enterprise-wide quality and patient safety priorities, performance, and action plan. Its membership includes key clinical and operational leaders from across the clinical enterprise, the Office of the Vice Chancellor for Health Affairs, and UIC health sciences colleges.

FY20 Quality & Patient Safety Goals

In July 2019, UI Health's Planning Construct including Goals, Initiatives, and FY20 Performance Goals were finalized. The FY20 Quality & Patient Safety priorities and performance targets have been set based on the University of Illinois Hospital and Clinics' (UIH) historic performance as well

as internal and external benchmarks. We have also worked to ensure alignment with how we are evaluated by regulatory and other rating organizations.

Ensuring Alignment with External Ratings:
Numbers Indicate Weighting of Performance Dimensions

	CMS Value-Based Purchasing	CMS Star Rating	US News and World Report	Leapfrog	Vizient Quality & Accountability
Safety[1]	25%	22%		50%	25%
Mortality[2]	25%	22%	37.5%		25%
Patient Experience	25%	22%	5%	16%	10%
Readmission		22%			8%
Reputation			27.5%		
Other[3]	25%	12%	30%	34%	32%
Total	100%	100%	100%	100%	100%

[1] Includes CLABSI, CAUTI, SSI, MRSA, C. Diff and other Patient Safety Indicators

[2] Sepsis is involved in ~ 50% of all UIH mortality cases

[3] Includes effectiveness, timeliness, efficiency, cost reduction, Magnet status, ICU staffing, and other

Our FY20 goals are as follows:

1. **Quality:**
   - Reduce Sepsis Mortality Index by 12.5-25%
   - Improve Postoperative Blood Clots by 12.5-25%
   - Reduce 30-Day Readmission Rate by 5-10%
   - Meet Minimum Surgery Volume recommendations for at least 75% of designated surgery types
   - Meet Critical Care-Certified Intensivist Staffing recommendations for at least 75% of Intensive Care Units

2. **Safety**:
   - Ensure Two Patient Identifier adherence exceeds 98%
   - Reduce Patient Safety Events by 5 to 10%
     - Central Line-Associated Blood Stream Infections

- o Catheter-Associated Urinary Tract Infections
- o Surgical Site Infections
- o Post-Operative Deep Venous Thromboses and Pulmonary Emboli
- o Inpatient Falls Resulting in Injury
- o Hospital-Acquired Pressure Injuries
- o Medication Errors Resulting in Harm
- o Sentinel Events
- Reduce Employee Safety Events by 5 to 15%:
  - o Sharps Injuries
  - o Injuries from Patient and Equipment Handling
  - o Slips, Trips, and Falls
  - o Injuries from Physical Altercations

All improvement targets are relative to UI Health's baseline performance as of June 30, 2019. For each of these priority areas, multidisciplinary project teams and detailed project plans have been formed and implementation of those plans is continuing.

Performance is being tracked monthly by Senior Leadership and QSSL, and progress is shared broadly each month throughout UI Health.

All of our teams will continue to be deeply engaged and actively supporting the successful development and implementation of Epic over the coming year.
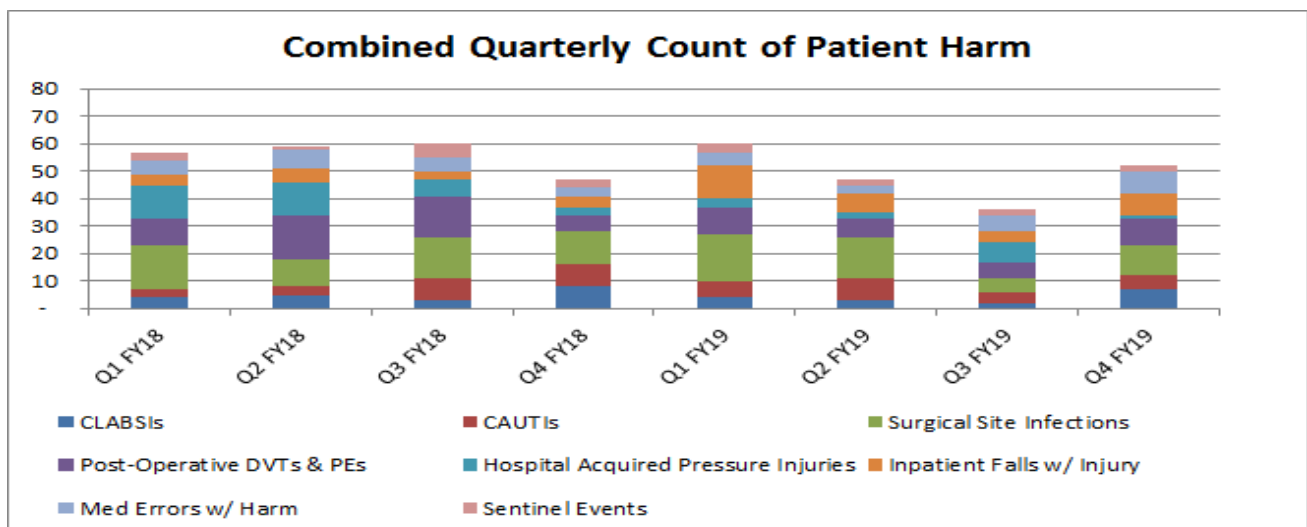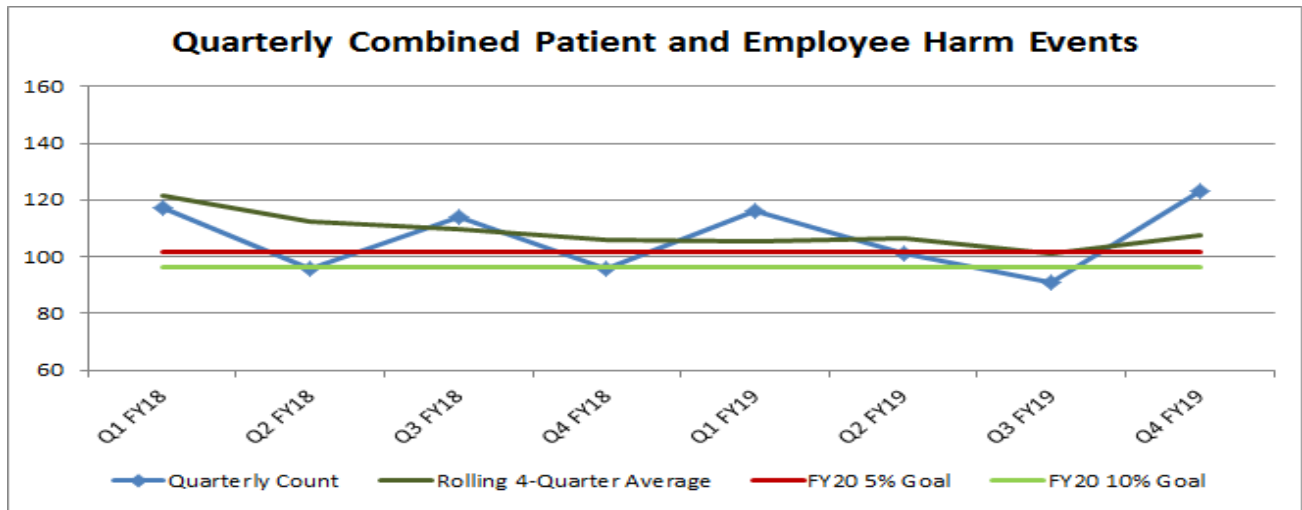
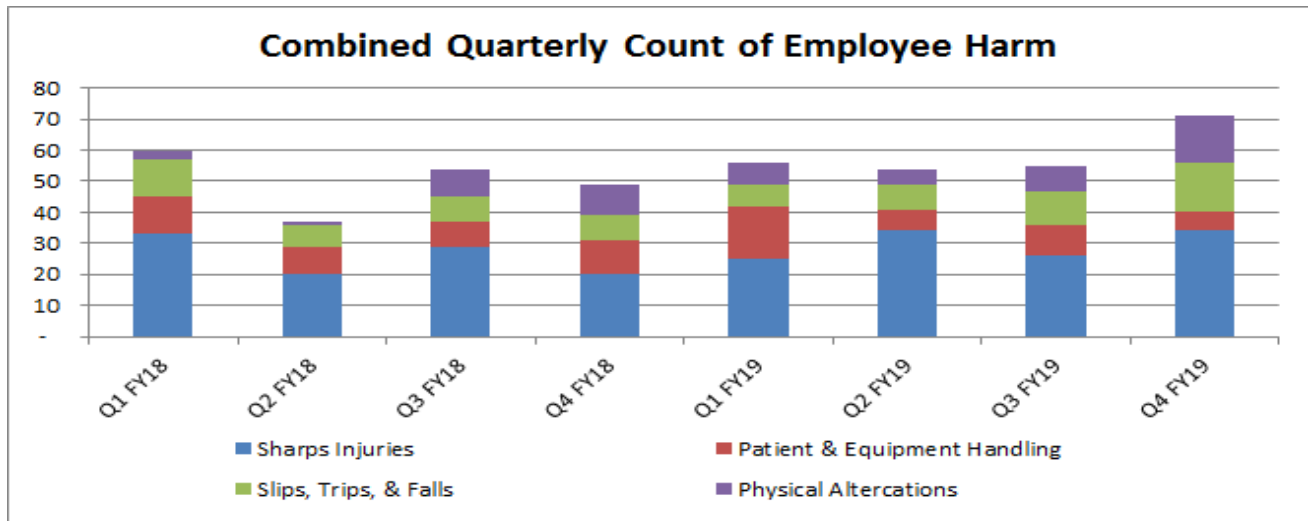**Continuing Improvements and Quality & Safety Performance**

The majority of our FY20 priorities were areas of focus in previous years. Wide-spread involvement and support from leaders and staff across our organization are resulting in continued measureable improvements in most areas, as summarized here. We are reevaluting and refining our workplans for the areas where performance declined during 2019.

Quality & Safety Priority	CY19 Change (thru Nov 2019)	Change since 1/2013
Central Line-Associated Blood Stream Infections (CLABSIs)	45% ▼	86% ▼
Catheter-Associated Urinary Tract Infections (CAUTIs)	34% ▼	75% ▼
Surgical Site Infections (SSIs)	6% ▼	30% ▼
Hand Hygiene Compliance	4% ▲	11% ▲
Post-Operative Deep Venous Thrombosis (DVT) and Pulmonary Embolism (PE)	30% ▼	69% ▼

Quality & Safety Priority	CY19 Change (thru Nov 2019)	Change since 1/2013
Hospital-Acquired Pressure Injuries	38% ▼	77% ▼
Inpatient Falls resulting in Injury	4% ▲	4% ▲
Medication-Related Harm	5% ▲	8% ▼
Employee Harm Events	18% ▲	16% ▼
Sepsis Mortality Index (Observed / Expected)	1% ▲	7% ▼

▼ ▲ Green arrows indicate improvement
▼ ▲ Red arrows indicate decline in performance

Quarterly Combined Patient and Employee Harm Events

Legend: Quarterly Count — Rolling 4-Quarter Average — FY20 5% Goal — FY20 10% Goal

Combined Quarterly Count of Patient Harm

Legend: CLABSIs, CAUTIs, Surgical Site Infections, Post-Operative DVTs & PEs, Hospital Acquired Pressure Injuries, Inpatient Falls w/ Injury, Med Errors w/ Harm, Sentinel Events

Combined Quarterly Count of Employee Harm

Legend: Sharps Injuries · Patient & Equipment Handling · Slips, Trips, & Falls · Physical Altercations

Accreditation & Clinical Compliance

The Accreditation & Clinical Compliance team facilitates ongoing readiness strategies to promote compliance with standards for accreditation by The Joint Commission (TJC), as well as other regulators including the Centers for Medicare and Medicaid Services (CMS) and the Illinois Department of Public Health (IDPH).

Methods utilized include risk assessments, improvement action plans, "tracers" (where patients and processes are followed through their normal course to analyze our systems of providing care, treatment, and services), team environmental rounds, staff huddles (brief regular meetings, for example at the start of each shift, where key information is shared with the entire team), policy development, an accreditation website with resources, and various education programs.

In 2019, the Accreditation team supported *numerous successful site visits* including:
- The Joint Commission full unannounced Hospital Accreditation Survey (3-year cycle)
- The Joint Commission Comprehensive Stroke Recertification (2-year cycle)
- CMS Complaint Allegation Investigation in the Emergency Department

In addition, Accreditation participated in *key initiatives supporting compliance standards*:
- *Extensive organization-wide preparation for the 3-year Joint Commission Hospital Accreditation survey*, including dry-run prep sessions for survey sessions, patient tracers, system tracers of high risk areas, facilitation of action plans, policy updates, and education/communication to all levels of staff, leaders, and clinicians.
- *Leadership of the accreditation survey* Command Central response to coordinate the 4-day Hospital survey activities and assure timely provision of requested documents and interview candidates. The Joint Commission surveyors commended the electronic document repository created to provide all surveyors with requested documents.

- *Continued implementation and sustainability*, prior to the September 2019 TJC hospital survey, of 2018 Patton Healthcare Consultation recommendations for compliance in the hospital and clinics.
- Service as an *advisory member of the Medical Staff Bylaws Committee*, to rewrite and enhance the Bylaws, which were completed and approved by the Board in 2019.
- *Implementation of new Joint Commission safety goal requirements* for Suicide Prevention that went into effect July 2019.
- *Redesign of the Hospital Policy review process* to incorporate nursing shared governance to ensure important staff input into policy development and to support Magnet goals.
- *Gap analysis and implementation* of strategies to achieve compliance with pharmacy compounding areas as a high risk area.
- *Initiation of an Accreditation Orientation program*, in collaboration with Nursing, to provide new nursing leaders with information and tools to support compliance with standards that support patient and employee safety.
- Hosting of Vizient Accreditation webinars twice a month for hospital leaders on *high risk accreditation topics and best practice implementation strategies*.
- *Advising hospital and medical staff leadership* on Joint Commission expectations of leadership and progress of action plans to improve compliance.
- *Advising various Epic planning groups on regulatory requirements* specific to workflow decisions as part of design for the new system.
- Collaboration with Laboratory Services on *preparation for 2-year Joint Commission Point of Care Testing (POCT) Laboratory Survey* expected between December 2019 and March 2020.

Clinical Documentation Improvement

Ensuring a complete and accurate record of our patients' care
- *facilitates communication and coordination* between all members of the care team by providing a clear picture of the patient's clinical status and treatment plan;
- *enables us to capture the true acuity of our patients,* including severity of illness and risk of mortality;
- *supports accurate external quality ratings,* such CMS Star, Leapfrog, and US News & World Report rankings; and
- *ensures we are being appropriately compensated* by payors and pay-for-performance programs like CMS' Value-Based Purchasing.

For these reasons, our Clinical Documentation Program is an essential part of UIH's quality and safety program.

The Clinical Documentation Program consists of three key groups: Physicians and Advanced Practice Providers, Clinical Documentation Improvement (CDI) Specialists, and Coders — who convert our written documentation into ICD-10 codes and DRGs for external reporting and billing

purposes. The CDI Specialists serve as the "bridge" between providers and coders; they help piece together information from the medical record and send queries when clarifications are needed to ensure the patient's clinical story is accurately reflected in the coded record.

In July, a company with expertise in clinical documentation did an assessment of UIH's CDI program. They found numerous improvement opportunities in both the documentation and coding of patient care. The biggest opportunity is more accurate capture of the severity of our patients' conditions; major complications and co-morbidities are under-documented, which is having a direct (negative) impact on external ratings.

This fall, implementation of the recommendations from this assessment began to enhance the "people," "process," and "technology" aspects of our CDI program. This improvement plan includes:
- ***Completion of a robust training curriculum by all CDI Specialists and Coders***
- ***Moving the CDI Specialists onsite*** to ensure availability as in-person resources for clinicians
- ***Adding more CDI Physician Liaisons to the team***
- ***Enhancing physician training*** on documenting more efficiently and thoroughly, and
- ***Sharing data on key metrics*** to track progress and identify additional opportunities for improvement.

Infection Prevention & Control

The Infection Prevention & Control team's 2019 priorities included:
- Maintaining our improvements in ***hand hygiene, central-line-associated blood stream infections (CLABSIs), and catheter-associated urinary tract infections (CAUTIs)***
  - CLABSI reduction efforts focused on 6W Medical ICU and 6E Neurosurgery/Neurology as well as 7W Organ Transplant/Surgical Intensive Care Unit.
  - CAUTI reduction efforts focused on 7W Stepdown and 6W Medical ICU.
  - We continue the practice of peer coaching with two new part-time staff hired to improve hand hygiene compliance by providing real-time observation and feedback to clinical staff.
- Continued leadership of ***Surgical Site Infection multidisciplinary workgroups*** with focus on:
  - General Surgery – Colon resections
  - Women's Health – Abdominal and Vaginal Hysterectomy and C-Section
  - Orthopedic Surgery – Total Hip and Total Knee
- Reducing healthcare-associated ***Clostridium difficile*** and other High Risk Organism infections
- Focus on ***Candida auris,*** including initiation of screening for this emerging pathogen
- Detailed ***analysis of each healthcare associated infection*** to identify patterns, trends, and opportunities for improvement

- Ongoing collaboration with University Health Service to eliminate *sharps injuries and blood borne pathogen exposures*
- Continued partnership with *procedural departments* to ensure that all equipment is properly processed and disinfected
- *Collaboration with design teams* for revision of Interventional Radiology, creation of Urology Clinic, and the new Outpatient Surgical Center.
- Ongoing *collaborations with leaders and staff* to improve infection control practices and to educate patients and our workforce on key infection prevention topics
- Supporting the successful fourth year of our *mandatory influenza vaccination program* for all UI Health employees that achieved 100% compliance (6182 out of 6,182 employees) during the 2018-2019 influenza season (October 2018 through March 2019). For the 2019-2020 season, the compliance deadline was moved to November 30, 2019.

Patient Safety & Risk Management

Our Patient Safety & Risk Management team is continuing its work to provide risk identification, assessment, consultation, education, and support to further elevate and improve the safety of UIH care processes and systems.

Risk Identification
Implementation of an updated electronic patient safety reporting system was completed in January 2017. The enhanced system provides improved data analytics and access to comparative data from other academic medical centers through our membership in a Patient Safety Organization (PSO). Participation in a PSO provides a "safe table" environment for discussing safety events as well as access to best practices and process improvements implemented by other leading healthcare delivery organizations.

Approximately 7500 patient safety event reports were submitted by UIH providers and staff during 2019. The most frequent report events were related to workplace behavioral events, care coordination, and patient refusal of treatment. Our second PSO Feedback Report, comparing UIH's 2018 patient safety event data with other academic medical centers, was received in September. Opportunities identified in the Report to focus patient safety initiatives and related process improvements include patient behavioral events, care coordination and communication related to against medical advice (AMA) discharges, and patient falls with harm. In comparison to our PSO peers, we had similar report findings in terms of patient harm and near-miss rates. We trended higher than our peers in the number of behavioral events, patient treatment refusals, AMA discharges, and cardiac complications. The findings of the Report are currently under review by the Medical Staff Review Board (MSRB) and the QSSL. Based on evaluation of the Report's findings, these committees will recommend patient safety priorities to medical staff and administrative leadership.

Risk Management Consultation and Education

The Patient Safety & Risk Management team provides 24/7 coverage for consultation with clinical and operational leaders and staff. Additionally, senior risk managers are assigned to clinical service lines and participate in quality improvement efforts, mortality and morbidity reviews, and staff meetings at both the enterprise and unit/service level to address risk issues and provide risk-focused education. Approximately 413 hotline calls were received and addressed by risk management staff in 2019. The Patient Safety & Risk Management internal website facilitates access to additional resources and information on safety and risk topics for all UI Health staff and clinicians.

Two enterprise-wide process changes led by the Risk team in 2019 include general consent redesign and surgical and procedural time-outs. General consent redesign addressed informing patients of myriad regulatory issues generally associated with billing, privacy, and patient communication. Compliance audits performed previously identified a significant gap with signed general consent forms in patients' electronic records. Risk Management staff engaged with Registration and other staff at all health system points of entry to facilitate re-consenting of all UIH patients. Similarly, the procedural time-out redesign involved enterprise-wide engagement of hospital staff. Ongoing monitoring of both processes demonstrates significant improvement in compliance and care processes.

Risk Management Assessment

The Patient Safety & Risk Management team provides ongoing assessment of high-risk areas for UIH and helps facilitate comprehensive reviews when potential patterns emerge. The Obstetrics Task Force, convened in early 2017 in response to a comprehensive risk assessment, recently completed its work plan and has been replaced by an Obstetrics Steering Committee. The Senior Director of Patient Safety & Risk Management serves on this committee, and the full Safety & Risk team continues to facilitate policy and procedure development, process redesigns, and achievement of specific improvements such as decision-to-incision time for C-sections. Similarly, the team is continuing to support risk- and safety-related improvements identified in a comprehensive review of our Child & Adolescent Treatment Unit that was completed in late 2017.

Patient Safety Services

Evaluating the safety of our care processes and systems includes the investigation of patient safety events and sentinel events – patient safety events that result in death, permanent harm, or severe temporary harm. Using an evaluation process aimed at determining the root causes of patient safety events, the Patient Safety & Risk Management team formally investigated 36 patient events from January through November 2019, 16 of which were deemed sentinel events. The most commonly occurring contributing factors identified as part of the root cause analyses were the lack of standardized workflows, variations in practice, staff competency, and inadequate communication.

The following *significant patient safety events* occurred and were evaluated in 2018 (sentinel events are asterisked):

- Permanent or temporary harm unrelated to underlying diagnosis * (8)
  - *intraoperative positioning injuries (3)*
  - *infant skull fracture during C-section (2)*
  - *missed contrast allergy requiring ICU stay (1)*
  - *TAVR (transcatheter aortic valve replacement) related death (1)*
  - *C-section with unplanned hysterectomy and ICU stay (1)*
- Unintended retained foreign object following an invasive procedure* (4)
- Patient fall resulting in permanent or temporary harm* (2)
- Delayed cancer diagnosis resulting in permanent harm* (1)
- Radiation therapy to wrong body area* (1)
- Significant physician behavior complaint (7)
- Procedural/surgical related harm
- Tissue storage in the OR
- Blood bank ordering issues
- Workplace violence – assault of employee/patient

Evaluation of these patient safety events has led to identification and implementation of improved processes and systems. These include standardized work flows, definition of standard work to reduce process variation, policy and procedure development and revision, work schedules to accommodate patient acuity, equipment upgrades, and staff education.

The Patient Safety & Risk Management team facilitates full disclosure to our patients and families when harm occurs. Team members provide coaching to clinicians preparing for communications with patients and families; they also attend and facilitate patient and family meetings involving communication of adverse events as requested. In addition, the team activates peer-to-peer support for clinicians who have been involved in or affected by patient harm events.

Safety Committee

The Safety Committee is a multi-disciplinary committee whose charge includes improving patient safety through implementing The Joint Commission's National Patient Safety Goals (NPSGs) and other hospital safety initiatives. The focus of the NPSGs includes: clinical alarm management; medication reconciliation; preventing surgical errors; preventing patient identification errors; improving prevention of blood clots; communicating critical test results; improving medication labeling in surgery and procedures; infectious disease prevention; and suicide screening and prevention.

Additional hospital safety initiatives overseen by this Committee include drug diversion, sharps injuries, rapid response teams, environment of care and workplace violence. The Department of Risk Management and Patient Safety partnered with nursing leaders on the Workplace Violence Committee to pilot and implement a Behavioral Response Team (Code BeRT). The Code BeRT

team responds to activation calls by Hospital staff that involve threats of patient, staff, or visitor harm. The Safety Committee reports quarterly to the Medical Staff Executive Committee and to the Senior Executive team.

A task force of Safety Committee members facilitated by a Senior Risk Manager are in the process of conducting a Failure Mode Effects Analysis (FMEA) on compliance with dietary orders, such as food restrictions and allergy identification. In addition to presenting a significant patient safety issue when dietary orders are incorrect, we have identified that this is also an area of decreased patient satisfaction. This FMEA is scheduled for completion and process implementation in early 2020.

Culture of Safety Action Plan and Survey
Our Culture of Safety Survey was last administered in March 2018 and demonstrated improvements in all categories in both our Inpatient and Ambulatory settings from our last survey in September 2016. The next Culture of Safety Survey will be administered in Spring 2020.

Participation in National Programs
UIH's Senior Director of Patient Safety & Risk Management serves as Chair of the Academic Medical Centers Risk Network for Vizient, a healthcare member organization comprised largely of academic medical centers whose goals include improving patient safety. The Senior Director led program planning and co-chaired the annual Risk Management Network meeting. In addition, she was named to the Editorial Board of the American Society of Healthcare Risk Management's (ASHRM) Journal of Healthcare Risk Management. Two of the three Senior Risk Managers achieved certification in Healthcare Risk Management by passing the national certification exam administered through ASHRM.

Peer Review Program
In support of a physician-led initiative to implement a multi-specialty peer review program, the Risk team has partnered with the office of the Chief Medical Officer (CMO), Medical Staff elected leadership, and the Medical Staff Office to develop a care review system that recognizes physician excellence as well as opportunities for improvements. The initiative was initially supported in early 2018 with the assistance of Greeley Consulting, a physician led company specializing in peer review and medical staff credentialing redesign. The Physician Excellence department is led by the Senior Director of Patient Safety & Risk Management, with reporting alignment for this function to the CMO. The Physician Excellence Review Committee (PERC) began formally meeting in January 2019; each of the 22 medical staff departments has a designated representative on the PERC. Two Physician Excellence nurse reviewers were hired along with a Business Administrative Associate to support this program.

In addition to performing case reviews, five physician enterprise metrics were monitored and reported monthly in 2019. Two of these metrics, documentation lag and verbal orders compliance, have reflected significant improvements in physician performance with completing clinic summary documentation and eliminating unnecessary verbal orders. Exemplary physician

performance, as well as performance needing improvement, is communicated monthly to physicians, Department Heads, Chiefs of Service, and utilized by the Credentials Committee in formulating credentialing and privileging decisions.

Quality Performance & Improvement

Our Quality Performance & Improvement team continues to support UI Health in three primary ways:

1. *Planning, analytic support, and project management* for quality priorities
2. *Data collection, analysis, and reporting* of required quality performance metrics to external regulatory bodies and managed care programs
3. *Expansion of UI Health's "improvement capability and capacity"* through clinician education, consultation with leaders and staff, and facilitation of improvement teams

During 2019, the Quality team:

- Led initiatives that contributed to a *35% reduction in post-operative blood clots* in FY19 compared to FY18. This included collaboration with hospital leadership, providers, and staff to develop and implement a system-wide, in-person blood clot prevention education. Starting in February 2018, a team consisting of physicians, nurses, therapists, and pharmacists educated over 2200 providers and staff. The education will continue as an e-learning module for all new hires and annually for current providers and staff.
- Facilitated initiatives related to UIH's participation in the *National Surgical Quality Improvement Program* (NSQIP). A workgroup focused on reducing surgical site infections (SSIs) in patients after gynecologic surgery reduced abdominal hysterectomy SSIs by 47% in FY19 compared to FY18.
- Continued to perform ongoing analytics and reporting support for both the *Blue Cross Blue Shield Managed Care* outpatient programs and the *Hospital Improvement Innovation Network* initiative to reduce all-cause inpatient harm.
- Delivered *consultative and analytics support* to multiple departments, including Pediatrics, Psychiatry, the Ambulatory Clinics (focusing on Diabetes and COPD), and Nutrition, as well as analytics support to the Department of Medicine.
- Provided project management and process facilitation for many of UIH's *Quality and Safety improvement priorities* including our Pain Committee. As an example, the Quality team facilitated the development and launch of a house-wide opioid therapy patient education program. The education was linked to nursing and physician discharge workflows to communicate safe use, storage, and disposal of opioids with patients. Results in FY19 include a 31% reduction in Naloxone use compared to FY18.
- Facilitated *collaboration between clinical teams and Epic to ensure proper build-out* for blood clot risk assessment and orders as well as federally reported measures related to sepsis, stroke, psychiatry, perinatal care, and emergency medicine.

- Continued collaborations with UIH Information Services staff, as well as external subject matter experts, to ensure compliance with mandatory electronic reporting of a subset of quality metrics (known as *eCQMs*) to CMS and The Joint Commission.
- *Hosted the 9th Annual Quality & Safety Fair*, which saw a sustained high level of participation as in previous years. There were 30 poster submissions describing a wide variety of initiatives resulting in improvements in processes, systems, care, and outcomes. Teams from three of our health sciences schools - Medicine, Nursing, and Pharmacy - joined dozens of UIH multidisciplinary teams in highlighting improvement work that ranged from clinical topics like improving influenza vaccination in the ambulatory setting, improving patient experience and outcomes in patients undergoing hip and knee replacement, reducing central line-associated bloodstream infections in the neonatal intensive care unit, and improving early mobility of patients through implementation of a house-wide, evidence-based mobility program.
- *Improved Medicare core measure performance* related to early management of patients with sepsis and septic shock, achieving a 47% improvement in sepsis bundle compliance in Fall 2019 compared to Fall 2018.

Supporting our Education and Research Missions

Our Quality & Patient Safety teams continue to provide support, consultation, and facilitation for the important body of work that collectively comprises UI Health's performance improvement journey. Some examples include the following:
- We are partnering with the College of Medicine to ensure successful implementation of the new Association of American Medical Colleges (AAMC) Entrustable Professional Activities (EPAs), primarily EPA13: Identify system failures and contribute to a culture of safety and improvement.
- We redesigned and deliver all course content on Quality and Patient Safety for the School of Public Health's Masters in Healthcare Administration (MHA) and Executive MHA programs.
- We advised the College of Nursing on its Bachelor of Science in Nursing and Doctorate of Nursing Practice curriculum revisions, including the development of Quality and Patient Safety courses that we help teach.
- The Senior Director of Risk Management partnered with the College of Nursing in its consulting assignment to the Illinois Department of Corrections (IDOC) to author a comprehensive program for implementing Quality, Patient Safety, Infection Control, Risk Management, and Peer Review.
- We developed and deliver a Quality in Health and Healthcare course for the College of Medicine's Department of Medical Education.
- Our leaders and staff also continue to provide frequent classroom training for undergraduate and graduate programs at most of our health sciences colleges.
- We continue to offer training to leaders and staff throughout our hospital and clinics on Improvement Methodology and basic improvement tools and techniques.

- A Leadership Book Club established in 2015 continues to serve as a forum for leaders across departments and disciplines to learn together and support each other through the challenges and successes of our efforts to improve care and outcomes at UI Health.
- We are currently partnering with the department of Graduate Medical Education, Program Directors, and attending physicians with expertise in improvement methodology on a standardized Quality Improvement curriculum for residents and fellows.