Reported to the Board of Trustees

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## 2021 Annual Quality and Patient Safety Plan

## University of Illinois Board of Trustees

## January 2022

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 Center.

The work of 2021 continues to be affected by the response to the COVID-19 pandemic. The Quality & Patient Safety Division has continued routine operations, but has provided critical support for the overall pandemic response.

# Quality & Patient Safety Division – Staffing 2021

The permanent UI Health Chief Quality Officer was named in July 2021.

The Quality & Patient Safety division comprises seven teams:

* Accreditation & Clinical Compliance: undergoing re-staffing of team in December 2021-January 2022
* Clinical Documentation Improvement
* Health Information Management and Privacy Office
* Infection Prevention & Control
* Patient Safety & Risk Management
* Quality Performance & Improvement: Director search December 2021
* Clinical Ethics Service

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

# Quality & Patient Safety Goals

The University of Illinois Health (UIH) Quality & Patient Safety priorities and performance targets have been set based on annual risk assessment that includes the 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.

UI Health FY22 Quality & Safety Goals are as follows:

* Reduce Patient Safety Events
* Reduce Employee Safety Events
* Improve Inpatient Experience Scores
* Improve Outpatient Experience Scores
* Improve Net Revenue
* Manage Operating Costs

The below goals make up the concise organizational goals above. These are identified as the key areas of performance needed to improve patient and employee safety and improve patient experience. Advancement in these areas will improve net revenue and operating costs through efficient high quality care.

*Quality and Safety Patient Events:*

* Decrease Sepsis Mortality Index
* Decrease post-operative blood clots
* Improve clinical documentation (measures by improved mortality index)
* Improve Patient Safety and Adverse Events Composite (PSI 90 composite)
* Decrease the incidence of retained foreign objects
* Decrease CLABSI rate
* Decrease CAUTI rate
* Decrease incidence of hospital onset Clostridiodes difficile
* Decrease the rate of colon surgical site infections
* Maintain or improve the rate of abdominal hysterectomy surgical site infections
* Decrease medication errors
* Decrease the need for naloxone use
* Decrease the incidence of falls with injury
* Decrease hospital acquired pressure ulcers
* Improve hand hygiene compliance
* Decrease length of stay
* Decrease readmission within 30 days

*Patient Experience Goals for Improvement:*

* Nurse communication
* Doctor communication
* Staff responsiveness
* Communication about medications
* Discharge information
* Transitions of care
* Hospital environment
* Ambulatory recommendations of facility
* Ambulatory provider communication
* Ambulatory staff worked together
* Diagnostics overall score
* Phlebotomy overall score
* ED doctor communication
* ED nurse communication
* Pediatric nurse communication

*Staff Wellness & Safety Events Goals:*

* Improve practitioner engagement
* Improve employee engagement
* Reduce total employee harms
* Reduce sharps injuries
* Reduce patient and equipment handling injury
* Reduce slips, trips and falls
* Reduce physical alterations

*Patient Quality Health Equity Initiatives*

This program is supported through an incentive based collaboration with Blue Cross & Blue Shield. The quality health outcomes component of the program tasks UIH with identify 4 inpatient and 4 outpatient quality health outcomes and to decrease disparities across race and ethnic demographics. UIH chose the following quality outcomes based on historical performance and comparative benchmarks:

* Reduce colon and hysterectomy procedure surgical site infections
* Reduce post-operative sepsis
* Reduce post-operative venous thrombosis
* Reduce hospital acquired pressure ulcers
* Reduce time patients spend in the ED before being sent home
* Reduce ED patients leaving without being seen
* Reduce 7-day admission rate after outpatient colonoscopy
* Reduce admissions after receiving outpatient chemotherapy

# Annual Summary & Department Level Goals

The above goals have been determined through evaluation of FY21 performance and the work of Quality and Safety Committees and Departments as outlined below with information on FY21 work and ongoing and planned work for FY22.

COVID-19 Impact on Ratings and Metrics:

External measures continue to be impacted by the COVID-19 pandemic. Changes in deadlines and exceptions for reporting related to the pandemic impact the performance periods for external measures.

CMS Value-Based Purchasing and CMS Star Ratings will not use data from Q1 and Q2 of calendar year 2020. Measurements from performance in CY2020 is typically reflected in performance of CY2021-22. Although the data will not be reviewed externally, we have internally evaluated performance and determined the goals for FY22.

**Summary of FY21 goals and achievement**

1. **Quality:**

* Reduce Sepsis Mortality Index (goal 1.5)
  + FY21 1.6
* Improve Postoperative Blood Clots (goal 6.36)
  + FY21 7.98
* Reduce 30-Day Readmission Rate (goal 4.5%)
  + FY21 19.13%
* Meet ICU Physician Staffing (goal 100% highest intensivist staffing standard)
  + FY21 100%
* Improve Documentation & Coding Performance (goal mortality ratio 1.10)
  + FY21 1.15

1. **Safety**: (sub categories unchanged)

* Reduce Patient Safety Events (goal 43.51)
  + FY21 46
* Reduce Employee Safety Events (goal 47.1)
  + FY21 62.6
* Mitigate Staffing Shortfall Events (goal 17)
  + FY21 6
* Continue Two Patient Identifier Adherence (goal 99%)
  + 99.4%

Quality & Safety Strategy & Leadership Steering Committee

The Quality & Safety Strategy & Leadership Steering Committee provides 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.

Accreditation & Clinical Compliance Team

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; policy development; an accreditation website with resources; and various education programs.

In CY2021, the Accreditation team supported again ***numerous successful site visits***. The number of visits continue to exceed years prior to the COVID-19 pandemic.

FY22 Accreditation & Compliance Goals:

1. Readiness for TJC survey including education, audits, leadership engagement, and gap identification. Performed a focused standards assessment in the 4th quarter of FY21.

Top elements of performance (EP) risk identified:

* Electronic health record advanced directives and informed consent
* History & Physical documentation of operative or high risk procedures
* Hand hygiene performance
* Process of restraint and seclusion
* Medication reconciliation
* Suicide prevention
* Universal precautions
* Assessment and reassessments of provisions of care
* Assessments of fall risk
* Pain management

1. Expansion of ambulatory locations to the Outpatient Surgery Center and Specialty Clinics (OSCSC) and other locations will need regulatory support for those that fall under the Hospital’s TJC accreditation.
2. Some services with expanded practices, such as ambulatory behavioral health will need regulatory support.
3. With electronic health record optimization now that EPIC has been implemented, optimization includes developing processes to ensuring regulatory compliance and utilizing tools to audit consistent practices and processes outlined in our policies for patient safety and quality care.
4. With the expanded needs of the organization and due to retirement of 2 staff within the last year, re-staffing and expansion of the accreditation team has been a priority for the department in CY2021 and into CY2022.

Clinical Documentation Improvement (CDI)

The Clinical Documentation Program consists of three key groups: physicians and advanced practice providers, clinical documentation improvement (CDI) specialists, and coders— who convert 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.

Many of the quality metrics are measured by observed incidence over expected incidence (O/E). Expected incidence is calculated by documentation and coding. Through audit it was determined that UIH documentation and coding did not reflect the complexity of care and decision making provided and thus a negative impact on our external ratings. Consistent provider response to documentation queries was a goal of FY21; this has been achieved. Goal of mortality index was 1.5; however, FY21 performance was 1.6.

FY22 CDI goals:

* Improve mortality index through CDI.
* Improve case mix index through CDI.
* Continued focus on improvement in clinical documentation through audit, feedback, and education.
* Rapid review of hospital acquired conditions (HAC), and mortalities by the CDI team.
* Review of documentation to support length of stay by CDI team.

Infection Prevention & Control

The Infection Prevention & Control Department continues to support the COVID-19 response through policies, education, audit and contact tracing. A contact tracing team through the support of the Chicago Department of Health and the Division of Infectious Diseases has been developed and is integrated with the infection prevention team.

Ongoing infection prevention needs and activities have continued as well. An annual risk assessment and plan was completed with goals for FY22.

Key Performance:

|  |  |  |
| --- | --- | --- |
|  | FY20 Observed/Expected | FY21 Observed/Expected |
| CLABSI | 1.029 | 0.85 |
| CAUTI | 0.101 | 0.476 |
| Hospital onset C. Difficile | 0.875 | 1.026 |
| Colon procedure surgical site infections | 2.481 | 0.806 |
| Abdominal hysterectomy surgical site infections | N/A | 2.558 |
| MRSA Blood | 0.815 | 0.654 |

FY22 Infection Prevention goals:

1. Continue to support outbreak response and emerging pathogens preparedness to minimize risk to patients, staff and visitors.
2. Ensure compliance with OSHA Emergency Temporary Standard for COVID-19
3. Ongoing collaboration with University Health Service to eliminate ***sharps injuries and blood borne pathogen exposures***
4. Review infection prevention needs and risk with increased construction areas and expansion.
5. With the expansion of ambulatory work, evaluate clinical practices proposed to ensure infection prevention measures in the environment and anticipated need for disinfection of reusable medical equipment.
6. Continued partnership with ***procedural departments*** to ensure that all equipment is properly processed and disinfected
7. Support the ***mandatory influenza and now COVID-19 vaccination program*** for all UI Health employees.
8. Improve hand hygiene compliance through champion rounding and intervention on all shifts and areas.
9. Detailed ***analysis of each healthcare associated infection*** to identify patterns, trends, and opportunities for improvement and Improve rates of healthcare acquired conditions (HAC)
   1. Hospital onset Clostridiodes difficile
   2. Device related infections – CLABSI, CAUTI, ventilator associated events
   3. Multidrug related infections
      1. Candida Auris
         1. Increases with Warren Barr admissions
      2. Other MDROs (VRE, CRE)
      3. Improve antimicrobial stewardship interventions
   4. Surgical site infections
      1. Colon
      2. Vascular
      3. CABG
      4. Medium risk
         1. Hysterectomy (abd and vaginal)
         2. Csection
         3. Ortho hip
         4. Laminectomy
         5. Craniotomy
10. For all health outcomes, evaluate for disparities across demographics.

Patient Safety & Risk Management

Risk identification:

* Vizient Electronic Safety Reporting System and Patient Safety Organization
  + Provide data analytics with comparative data across medical centers along with collaboration and sharing of best practices for process improvement plans
* Risk team participates in mortality and morbidity reviews with various service lines
* Filed litigations – the Patient Safety & Risk Management Team collaborates with University Legal Counsel
* Patient Safety Events – The Patient Safety & Risk Management Team provides 24/7 coverage for consultation with clinical and operational leaders and staff. Patient safety and sentinel events are investigated through a root cause analysis or critical incident debrief.

Most Common Events in the Hospital:

* Care coordination / communication
* Call to medical response team
* Behavioral event
* Other / miscellaneous
* Medication related
* Complications of care (unanticipated, non-surgical)
* Fall
* Event relating to surgery or invasive procedure
* Laboratory test

Most Common Events for Ambulatory Care:

* Medication-related
* Call to Medical Response Team
* Fall
* Laboratory Test
* Other
* Behavioral
* Complications of Care (unanticipated, non-surgical)
* Care Coordination/Communication
* Medical Records/Patient identification
* Radiology/imaging test

Risk Mitigation Assessment:

Safety events and claims are reviewed based on prevalence and impact on safety for risk prioritization.

High risk priority for mitigation:

* Retained foreign objects
* Resident supervision
* Neurosurgery litigation
* Obstetric litigation
* Patient and visitor violence
* Suicide risk and care environment

Moderate risk priority for mitigation:

* Caregiver disruptive behavior
* Inconsistent Documentation
* Falls with harm
* Surgical positioning

Medical Staff Review Board

The Medical Staff Review Board is a committee of the medical staff and is co-chaired by the Senior Director of Patient Safety & Risk to evaluate and prioritize system related risk and safety issues to improve the quality and safety of patient care at UIH. With resident supervision a key area for mitigation, the Associate Dean for Graduate Medical Education has been added to the MSRB in 2021. A resident safety council was started in 2021.

Peer Review

The Physician Excellence Review Committee (PERC) is made up of representatives from the 22 medical staff departments along with the Senior Director of Patient Safety & Risk Management. The Risk department supports this program though case review, and expertise.

Exemplary physician performance, as well as performance needing improvement, is communicated monthly to physicians, department heads, chiefs of service. This information is utilized by the Credentials Committee in formulating credentialing and privileging decisions. In 2021, Ongoing Professional Practice Evaluation (OPPE) metrics have been reviewed and are being updated to align with organizational quality and safety goals.

Care for the Caregiver

The Patient Safety & Risk Management team facilitates full disclosure to our patients and families when harm occurs. Team members attend and facilitate patient and family meetings involving communication of adverse events as requested. The Care for the Caregiver program continued to expand in 2021 to train clinicians in peer-to-peer support for those involved in or affected by patient harm events and to promote a culture of safety.

Safety committee

The Safety Committee is a multi-disciplinary committee co-chaired by the Senior Direct or Patient Safety & Risk Management, 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.

Culture of Safety Action Plan and Survey

Our Culture of Safety Survey was administered in April-May 2021 in combination with the engagement survey. Overall safety culture index is below the national averages. Resilience and decompression index were also below the national average. This may be related to pandemic fatigue as challenges with COVID-19 and hospital capacity continue in 2021. Department and service line leaders reviewed their team data and developed action plans. Communication was identified as an organizational goal to improve culture of safety and progress on action plans will be reviewed in FY22-23.

CORS Program – Co-Worker Observation Reporting System™

The CORS program was initiated in FY22Q1. This is a program sponsored by Vanderbilt and is an extension of the Patient Advocacy Reporting System (PARS). CORS documents unprofessional behavior and utilized peer coaching to improve professionalism and behavior. Lessons about the impact of unprofessional behaviors from the PARS and now the CORS programs has yielded statistically significant data published in JAMA and other medical and patient-safety journals demonstrating the link between patient complaints and unprofessional co-worker behavior that leads to increased medical malpractice cases, in addition to increased patient complications. The program has been initiated with physician reporting and will be expanded to nursing and trainees in CY22.

**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

3i Implementation and Optimization Support:

* Working with IS and Sepsis Core Committee to validate and optimize Epic Sepsis dashboard and reports
* Working with IS and Anticoagulation Steering Committee to optimize anticoagulation orders (completed), nursing documentation of intermittent pneumatic compression (IPC) devices, and validate/update anticoagulation medication and IPC refusal reports (completed)
* Working with the inpatient adult psychiatric team to optimize clinical workflows and ensure compliance with core measures
* Working with IS and the stroke team to validate/update CMS electronic clinical quality measures (eCQM) dashboard
* Working with IS and Pain Committee to create opioid orders reports
* Worked with IS to ensure core measures and eCQM were captured as part of clinical workflows

Quality Performance and Improvement:

* Continues to lead initiatives to reduce post-operative blood clots. This included collaboration with hospital leadership, providers, and staff to develop and implement a system-wide, in-person blood clot prevention education
* 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 to zero in CY19. A program to address colon surgery infections began in fall 2020.
* 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.
* Will support a new Blue Cross Blue Shield quality improvement program addressing diversity and disparity.
* 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.
* 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 11th Annual Quality & Safety Fair, which was again virtual due to the COVID-19 pandemic. There was excellent engagement with 49 posters being submitted from multidisciplinary teams dedicated to patient safety and quality care at UI Health.

**Health Information Management and Privacy Office**

* Collaborated with Epic on all tasks related to the build and testing of Epic HIM and Identity modules/workflows
* Served as a privacy expert and resource for Epic HIE initiatives (Epic Care Everywhere; Epic CareLink) and other functionalities (Break the Glass, restrictions, etc.); developed multiple forms (proxy forms, HIE consents); assisted with drafting consents, agreements, etc.
* Implemented on-line medical record request tool to enhance patient experience.
* Collaborated with medical staff to improve timely documentation impactful on patient safety and revenue.