Reported to the Board of Trustees
January 21, 2021

2020 Annual Quality and Patient Safety Report
University of Illinois Board of Trustees Meeting
January 2021

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.

In summary of the work of 2020, it must be highlighted that the year has been dominated 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. The work from the year is highlighted below with the overlay of the impact of COVID-19 on safety and quality measures.

Part of the strategic plan for the organization and for the Quality and Safety Division included a critical operational infrastructure of the 3i Project Implementation. This was postponed because of the COVID-19 pandemic from May to September 2020. Many of the improvement plans included improved data and dashboard development with the 3i project. This remains a critical operational infrastructure

Quality & Patient Safety Division – Staffing 2020

The Interim UI Health Chief Quality Officer was named in January 2020

The Quality & Patient Safety division comprises six teams:

- Accreditation & Clinical Compliance: Interim Director named in March and New Director named in October 2020
- Clinical Documentation Improvement: New Director named in January 2020
- Health Information Management and Privacy Office
- Infection Prevention & Control
- Patient Safety & Risk Management
- Quality Performance & Improvement

An additional team was added to the Division in 2020

- Clinical Ethics Service

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

Quality & Patient Safety Goals

The 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.

COVID-19 Impact on Ratings and Metrics

External measures have been impacted by the COVID-19 pandemic. There have been changes in deadlines and exceptions for reporting related to the pandemic. To allow hospitals to address the crisis of COVID-19 some deadlines were postponed. Due to the increased severity of illness of patients with COVID-19 being admitted and decreases in non-urgent visits and procedures there were significant alterations in denominators for quality metrics and some of the regular measures were exempted because they cannot reliably calculate observed or expected comparators.

CMS Value-Based Purchasing and CMS Star Ratings will not use data from Q1 and Q2 of calendar year (CY) 2020. With the ongoing pandemic we have some expectation that these measures will not be included for the entire calendar year, but this has not been determined. It is difficult to anticipate how we will be measured from data in 2020. Measurements from performance in CY2020 is typically reflected in measures of CY2021. Although the data will not be reviewed externally, we have internally evaluated performance and determined the goals for FY21.

Summary of FY20 Goals and Achievement

Leap Frog submission was postponed from the spring until fall of 2020. Despite delay for submission of data and the COVID-19 pandemic response, we have achieved a grade of **"C" which is improved** from our fall 2019 grade of "D". This improvement in grade is related to the improvements in some of the UI Health goals listed below.

Quality

- Reduce Sepsis Mortality Index by 12.5-25%
  - **Decrease** but not to target level; will continue as organizational priority
- Improve Postoperative Blood Clots by 12.5-25%
  - **Decreased to target** in CY19 but with increased rates in CY20 due to COVID-19 risk of thrombosis; will continue as organizational priority.
- Reduce 30-Day Readmission Rate by 5-10%
  - **Increase**; will continue as organizational priority.
- Meet Minimum Surgery Volume recommendations for at least 75% of designated surgery types
  - **Did not meet target**; transitioned to surgeon volumes for organizational priority.
- Meet Critical Care-Certified Intensivist Staffing recommendations for at least 75% of Intensive Care Units
  - **Did not meet target**; will continue as organizational priority.

Safety

- Ensure Two Patient Identifier adherence exceeds 98%
  - **Achieved 100%**; will continue to maintain as organizational priority.
- Reduce Patient Safety Events by 5 to 10%

- Central Line-Associated Blood Stream Infections
  - **Decrease,** but increases seen related to COVID-19.
- Catheter-Associated Urinary Tract Infections
  - **Decrease**
- Surgical Site Infections
  - **Decrease** for some procedures, zero infections for abdominal hysterectomy in 2019.
- Inpatient Falls Resulting in Injury
  - **Decrease**
- Hospital-Acquired Pressure Injuries
  - **Increase**
- Medication Errors Resulting in Harm
  - **Increase**
- Sentinel Events
  - **Decrease**

- Reduce Employee Safety Events by 5 to 15%
  - Sharps Injuries
    - **Decrease**
  - Injuries from Patient and Equipment Handling
    - **Decrease**
  - Slips, Trips, and Falls
    - **Decrease**
  - Injuries from Physical Altercations
    - **Increase**

UI Health FY21 Goals

The UI Health FY21 Quality & Patient Safety Goals are:

Quality

- Reduce Sepsis Mortality Index
- Improve Postoperative Blood Clots
- Reduce 30-Day Readmission Rate
- Meet ICU Physician Staffing
- Improve Documentation & Coding Performance

Safety (sub categories unchanged)

- Reduce Patient Safety Events
- Reduce Employee Safety Events
- Mitigate Staffing Shortfall Events
- Continue Two Patient Identifier Adherence

Quality & Safety Strategy & Leadership Steering Committee

The Quality & Safety Strategy and Leadership Steering (QSSL) 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.

The QSSL committee has taken a pause to allow for attention to the COVID-19 response. This group will resume in a restructured format in 2021. Individual quality and safety work groups and committees have met as needed to maintain improvement momentum and to address COVID-19 related issues.

Accreditation & Clinical Compliance Team

COVID-19 Response Support

- Inform leaders and the organization of regulatory flexibilities allowed due to the public health emergency (i.e. waivers, alternative care sites, etc.)
- Modified policy review and approval process to accommodate increased demands placed on policy owners, many of whom are directors and clinicians.
- Work with clinicians to expedite approval of COVID-19 related clinical guidelines and protocols (prioritized getting documents posted as quickly as possible).

3i Implementation and Optimization

- Meet with an Epic project leader to discuss accreditation needs during Epic implementation.
- Worked with policy owners to identify policies needing revisions due to workflow changes.

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 2020, the Accreditation team supported ***numerous successful site visits***. The number of visits exceeded prior years dramatically related to the COVID-19 pandemic.

	Date(s)	Surveying Entity	Type of Survey	Result
1.	2/28/20	TJC	Lab accreditation	Accredited
2.	3/25-26/20	IDPH/CMS	Complaint	No findings
3.	4/29-30/20	IDPH/CMS	Complaint	No findings
4.	5/12/20	OSHA*	COVID employee deaths	No findings
5.	6/8/20	OSHA*	COVID PT & OT	No findings
6.	7/7-8/20	IDPH/CMS	Complaint	No findings

	Date(s)	Surveying Entity	Type of Survey	Result
7.	7/21/20	IDPH	Perinatal Re-designation	Re-designated
8.	8/25-26/20	IPDH/CMS	EMTALA	No findings
9.	8/25-26/20	IDPH/CMS	Patient rights-adult psych	Immediate jeopardy (patient safety). Removed 9/29 with full review.
10.	9/8/20	OSHA*	COVID-cafeteria	No findings
11.	9/12/20	IDPH/CMS	Complaint	No findings
12.	9/14/20	IDPH/CMS	Complaint	No findings
13.	9/29-10/2/20	IDPH/CMS	Complaint-Full hospital	Immediate jeopardy (physical plant). Corrective action A-tags (accepted).
14.	10/21/20	OSHA*	COVID Patient/Guest Experience Office	No findings
15.	11/5/20	OSHA*	COVID- employee EHR access	No findings
16.	11/19/20	OSHA*	COVID 7 East	TBD
17.	12/9/20	IDPH	PCCC/EDAP designation	TBD
		*off site investigation		
1.	1/13/20	TJC	Patient complaint-ED	Response accepted
2.	2/7/20	TJC	PICU employee complaint	Response accepted
3.	2/7/20	TJC	OR employee compliant	Response accepted
4.	2/27/20	TJC	CS Vendor compliant	Response accepted
5.	7/1/20	TJC	ED Employee complaint	Response accepted
6.	9/14/20	TJC	Employee Complaint	Response accepted

In addition, Accreditation participated in key initiatives supporting compliance standards:

- **Leadership of the CMS survey 9/29-10/2/2020**: Command Central response to coordinate the Hospital survey activities and assure timely provision of requested documents and interview candidates.
- Service as an **advisory member of the Medical Staff Bylaws Committee**, to update and enhance the Bylaw.
- **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.
- **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 (CDI)

COVID-19 Response Support

- CDI team served as the frontline investigator, searching for the connections in the words recorded (signs and symptoms) or missing in the documentation to a more definitive and specific diagnosis of COVID-19.
- CDI team attended seminars/training – COVID-19 Coding and Reporting and billing/claims aspects of COVID-19.
- CDI team are the keepers of the patient's clinical story by collaborative partnership with physicians and coders to ensure that patient's data is accurate and complete.
- Fully capture the comorbid conditions/diagnoses and organ system involvement.
- Triage documentation clarification, limiting queries to the most critical situations to avoid physician query fatigue (develop appropriate clarification strategies with busy physicians).
- Ensure present on admission status of COVID-19 cases presented with symptoms then subsequently tested for COVID-19 after admission.

3i Implementation and Optimization:

- CDI time had completed EPIC training as scheduled with additional/ongoing training until implementation and still an ongoing process.
- Timely review of medical records and ensure that clinical documentation supports patient care rendered.
- Proper utilization of CDI query/Inbasket – send documentation clarification request to physician.
- Assist physicians (physician education/clinical documentation tips) to ensure completeness of documentation in EPIC.
- Implementation of Optum, coding and documentation support aligned with EPIC.

The CDI 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 had a negative impact on our external ratings. Improvement in the CDI program was a strategic goal for FY2020 and continues as a goal for FY2021. The impact of the CDI program improvements will be reflected in CY2021-22.

Improving Clinical Documentation 2020

- A new Director of CDI was on-boarded in January of 2020.
- A robust curriculum was implemented to train CDI Specialists and Coders, this was completed in early 2020 with ongoing audit and review of education throughout 2020.

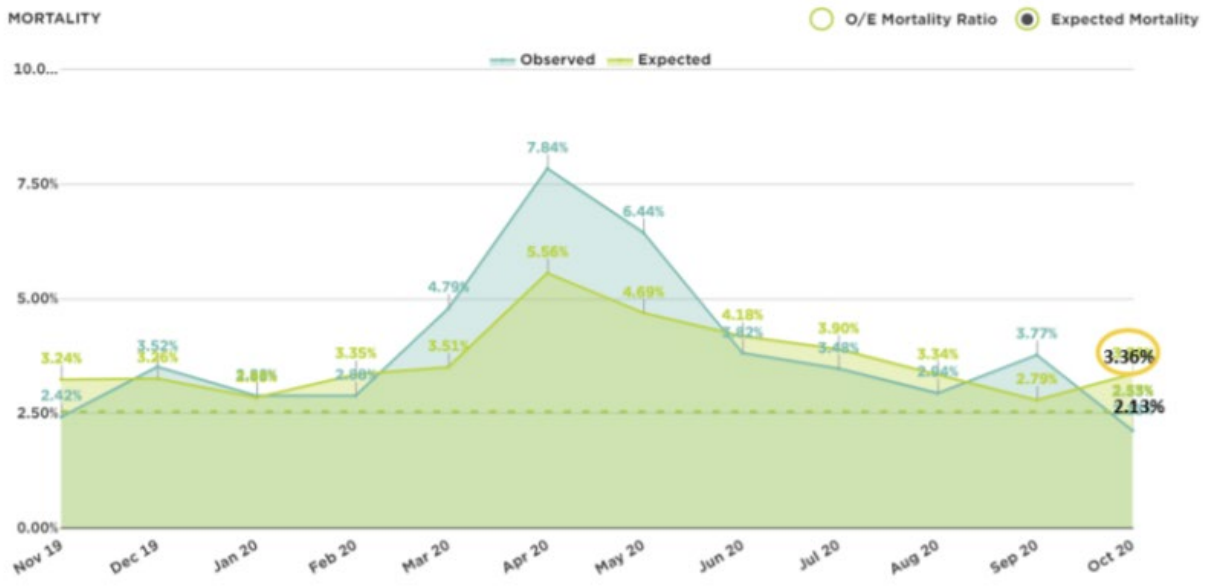
- 2 CDI Physician Liaisons were added to the team, and a third is being recruited for a total of 4.
- A CDI training program for physicians was implemented in early 2020 with a rotation to all clinical service lines include graduate medical education.

As seen in the graphics below, there was a dramatic increase in mortality related to COVID-19 infected patients in April and May. From June to October despite ongoing COVID-19 admissions there was a **more sustained improvement in mortality** observed over expected below 1 at 0.63.

OBSERVED AND EXPECTED MORTALITY - MEDICARE

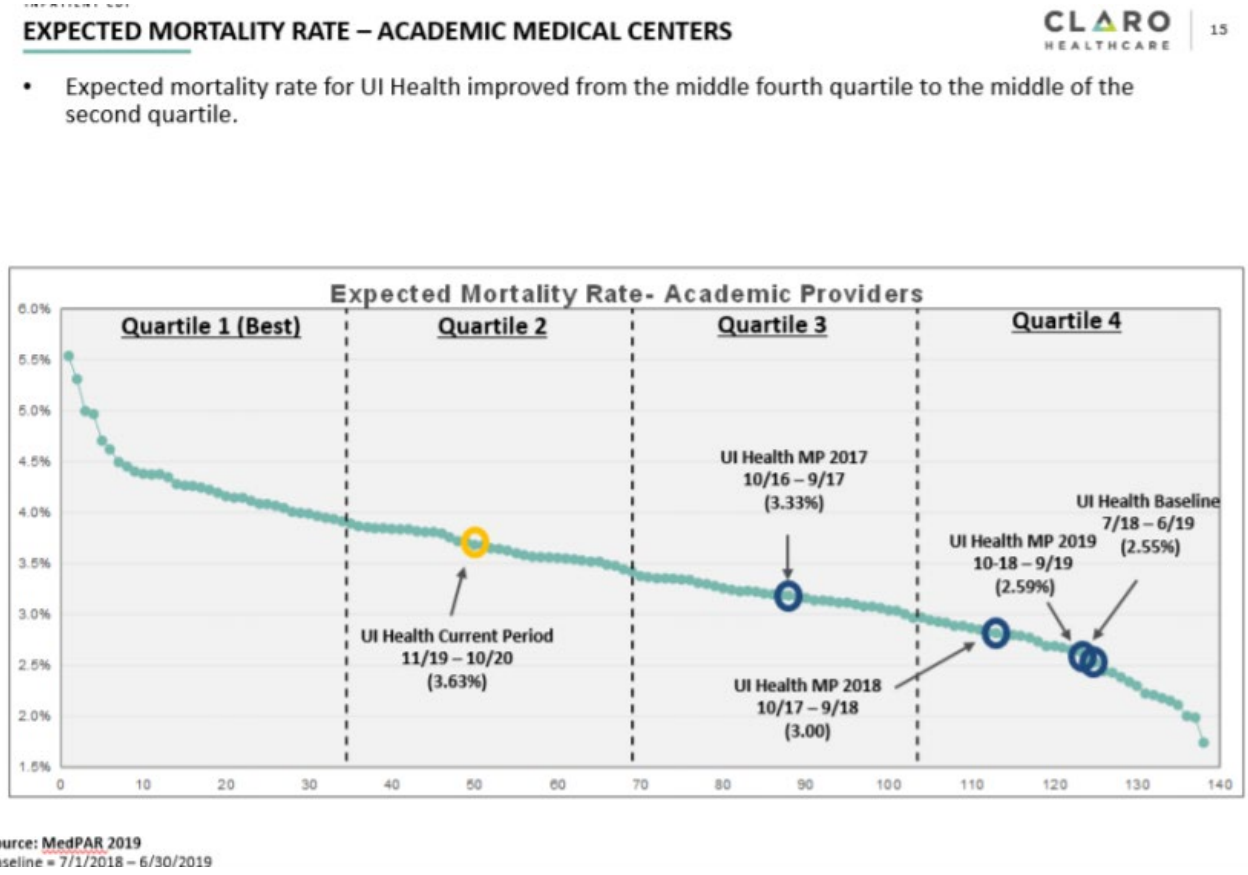
CLARO HEALTHCARE

- The expected mortality rate increased 42.31% in Year 1 compared to the baseline.
  - The October observed mortality rate decreased while the expected mortality rate increased compared to prior months which resulted in a favorable O/E ratio of 0.63, the most favorable to date.



1) October includes discharges through 10/31, and final billed as of 11/1. Metrics will update with future refresh of cases still in coding backlog.
2) Data includes Medicare Part B discharges.

The graphic below shows how UIH compares to other medical centers in expected mortality as a reflection of clinical documentation overall in 2020. This illustrates significant improvement in CDI to reflect the complexity of care and decision making for UIH patients. It is anticipated that this improvement will be reflect in external reputational measures in calendar year 2021-22.



Infection Prevention & Control (IPC)

COVID-19 Response Support

Much of the IPC team's work in 2020 has been directed at COVID-19 response.

- The Medical Director of IPC along with Director were initially responsible for reviewing and approving all testing for COVID-19, this transitioned to guideline based to allow for more expanded testing.
- The IPC team developed and implemented COVID-19 isolation guidance along with other clinical guidance.
- The IPC team contact traces patients with COVID-19 while at UIH, and collaborates with University Health Services to identify clusters and investigate outbreaks.
- The Medical Director and Director have provided expertise to the incident command structure for COVID-19 response and now for vaccine deployment.
- Through a partnership with the Chicago Department of Public Health and the College of Medicine, the IPC Director will assist with a contact tracing of all positive patients at UIH
- COVID-19 Policy and protocol creation and revisions

    - Updating and maintaining current practices and protocols to align with continuous CDC changing guidelines.
- PPE selection and modifications as new reduction in supply chain becomes evident
    - Research and development of systems to reprocess (e.g., goggles, face shields, N-95 respirators, half mask elastomeric)
    - Mask extended use/reuse guidelines
    - Face shield implementation
- Disinfection selection and modification as supply chain becomes unstable.
- Education of staff on various topics: testing, PPE education, Specimen collection, Disinfection.
- COVID-19 reporting to regulatory entities.
- Space assessment for proper work environment and spacing.
- Rounding / supporting / assisting with social distancing / patient flow in Outpatient clinics.
- Consultation for creation of testing sites and triage sites.
- Consultation for remodeling of patient care spaces to accommodate new types of patients:
    - Creation of new ICU beds,
    - Negative air modifications for clinics and inpatient rooms,
    - Additional negative air space in ED.
- Creation of space for monoclonal antibody infusion.

3i Implementation and Optimization

- Design of Bugsy, the Infection Prevention Module, and input into Beaker, the microbiology module.
- Validation of data to ensure reliability of EPIC.
- Building and running reports.
- Validating devices daily for central lines, urinary catheters, and ventilators.
- Troubleshooting with other departments and aligning needs.
- Multi departmental collaboration which supports infection prevention policies and guidelines (e.g., nurse driven protocol with indwelling catheters).

Infection Prevention 2020

- For the first time in 7 years there was a significant increase in the number of central-line-associated blood stream infections (CLABSIs). This has been seen in other medical centers and is likely related to prolonged hospitalization related to COVID-19. This was seen in the Q2 of 2020 and appears not to be sustained, but is a focus of ongoing prevention efforts for COVID-19 infected patients.
    - 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.
- 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
        - Work to date has achieved a rate of 0 reportable infections in 2019.
    - Orthopedic Surgery – Total Hip and Total Knee
        - Ongoing successes with reduction in SSI

        - Gage Award from Americas Essential Hospitals.
- Reducing healthcare-associated Clostridium difficile and other High Risk Organism infections
    - Achieved a standardized infection ration (observed/expected) less than 1.
- 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.
- 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 fifth year of our mandatory influenza vaccination program for all UI Health employees.

Patient Safety & Risk Management

COVID-19 Response Support

- Ethics Committee expertise input Risk expertise and guideline review.
- COVID-19 Inpatient Management Committee: risk expertise input and guideline development and review.

3i Implementation and Optimization:

- Extensive guidance provided to Task Force working on My Chart, Care Everywhere and development of appropriate patient consent language.
- Extensive Risk and Patient Safety guidance to clinical work flow development.

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

- Vizient Electronic Safety Reporting System and Patient Safety Organization
    - Provides data analytics with comparative data across medical centers long with collaboration and sharing of best practices for process improvement plans.
- 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.
    - 5 sentinel events were investigated from January – November 2020.
        - Retained foreign object
        - Patient Harm
        - Three falls with harm
- In January 2020, a new Critical Incident Debrief process was implemented with key stakeholders rapid review and debrief to develop response plan.

        - 10 completed in 2020 with themes of patient care management issues, hand-off communication, and physician behavior
- Risk team participation in mortality and morbidity reviews
- Filed litigations – the Patient Safety & Risk Management Team collaborates with University Legal Counsel

Risk Management
After identification and review there are several areas that can be utilized to address needed implementation.

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.

- As part of the expansion of the resident curriculum to include safety and risk, the Associate Dean for Graduate Medical Education has been added to the MSRB and resident participation will be added 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.
    - With the transition to EPIC in September of 2020 the business analytics team provides support to the program to generate other tracked metrics to improve physician excellence. In 2019 documentation lag and verbal orders compliance were part of the initial physician metrics. This process has been integrated into Epic with our Health Information Management team and it automated and preliminary data suggests reflected significant improvements in physician performance with completing clinic summary documentation.
    - 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.

Process Improvement Work Group

- Retained Foreign Objects Work Group
- Unexpected Finding Work Group
- Service line Programs
    - Obstetrics Steering Committee
    - Child & Adolescent Treatment Unit

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.
- 2020 Care for the Caregiver program implemented to train a team of 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.

- The Patient Safety & Risk Management Team facilitated a task force to conduct Failure Mode Effects Analysis (FMEA) on compliance with dietary orders, such as food restrictions and allergy identification completed and implemented in 2020.
- The Patient Safety & Risk Management Team facilitated a task force to conduct Failure Mode Effects Analysis (FMEA) on sharps injury.

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 was designated to be administered in Spring 2020. Due to the COVID-19 pandemic, this has been deferred. With this deferment, plans have been initiated to combine this survey with employee engagement survey to prevent survey fatigue and overall burnout in staff related to the ongoing pandemic response.

Quality Performance & Improvement (QPI)

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

COVID-19 Response Support

- Facilitate the COVID-19 Committee, focusing on updating clinical guidelines and orders.
- Track and provide dashboard tends daily of PPE, Ventilators, Employees with COVID-19.
- Maintained the REDCap COVID-19 test tracker.

3i Implementation and Optimization Support

The QPI works with the following teams and committees:

- IS and Sepsis Core Committee to validate and optimize Epic Sepsis dashboard and reports.
- 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).
- The inpatient adult psychiatric team to optimize clinical workflows and ensure compliance with core measures.
- IS and the stroke team to validate/update CMS electronic clinical quality measures (eCQM) dashboard.
- IS and Pain Committee to create opioid orders reports.
- IS to ensure core measures and eCQM were captured as part of clinical workflows.

Quality Performance and Improvement 2020

- Continues to lead initiatives to reduce post-operative blood clots. This includes 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.
- 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.
- 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 10th Annual Quality & Safety Fair, which was virtual due to the COVID-19 pandemic. There was excellent engagement with 41 posters being submitted from multidisciplinary teams dedicated to patient safety and quality care at UI Health.
- Improved Medicare core measure performance related to early management of patients with sepsis and septic shock.

Clinical Ethics

The director of clinical ethics joined the UIH team in August of 2020. The director provides ethics consultation related to clinical care, and support for institutional decisions. With COVID-19 pandemic response the clincal ethicist has been integral.

COVID-19 Response support

- Participation in COVID-19 Ethics Committee
- Participation in COVID-19 Vaccination prioritization

Health Information Management and Privacy Office

The Health Information Management and Privacy Office has been part of the infrastructure for COVID-19 response and critical support for 3i implementation.

COVID-19 Response Support

- Provided guidance on privacy related matters in light of COVID-19 pandemic; served as a resource to clinical areas as well as UHS regarding privacy and COVID-19 initiatives.
- Maintained stable operations during COVID-19 pandemic and organized labor negotiations.
- Implemented telecommuting process for HIM staff who was able to perform work remotely.
- Accommodated on site staff with work stations that allowed for social distancing; provided cleaning supplies to sanitize work areas; provided appropriate PPE to staff responsible for collecting records from units and clinics.
- Trained staff on virtual technology and implemented virtual huddles with staff.
- Volunteered HIM staff to the "labor pool" to assist in other areas due to COVID-19 related staff shortage.
- Established new release of information area in the hospital admitting department to assist patients with medical records requests.

3i Implementation and Optimization

- 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.
- Performed duplicate MRNs merges prior to go-live in effort to reduce the MRN duplicate rate to 2% as recommended by Epic.
- Assisted with remote (Webex) training of HIM staff on HIM functions in Epic; ensured super users support before, during and after go-live.
- Developed additional training materials and procedures to aid staff in successful transition to the new system and to help with completion of tasks in Epic.
- Ensured seamless integration of M*Modal transcription platform with Epic.
- Implemented new document scanning and management system (Hyland onBase) and integrated it with Epic; trained staff on new platform and processes.
- Built and implemented a new version of Optum Computer Assisted Coding platform and fully integrated it with Epic coding workflows.

- Enlisted help of coding agency and student-employees to allow for extra resources during Epic training and Epic go-live.
- Post Epic go-live, collaborated with HIM Epic analysts on resolution and troubleshooting of issues impacting HIM workflows (still ongoing).