

Reported to the Board of Trustees
November 9, 2006

Safety Report to the University of Illinois Board of Trustees for FY 2006
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2006 was a banner year for the Safety Program at the Medical Center. Several high risk areas were identified and changes made to improve care within those areas. Processes that traditionally have been the purview of individual departments, have been increasingly analyzed on a hospital wide basis and programs initiated to improve care across disciplines. Guidelines were developed and implemented for tracheostomy care, the prevention of thrombotic complications in hospitalized patients, and improved processes for the administration of cancer chemotherapy. We continued to evolve guidelines for the treatment of heart failure and the prevention of retained instruments and sponges at the time of surgery. These efforts have led to reductions in complications and improved outcomes across all these areas. Importantly, the efforts to reduce clinical morbidity also resulted in a drop in the cost of our excess insurance coverage.

Risk reduction efforts were also undertaken through multidisciplinary meetings with outside consultants for the implementation of our full disclosure and rapid settlement program. This includes utilization of patient complaint data to focus on predicting malpractice risk for individual care givers. The Medical Service Plan has created a committee to focus on methods to educate and provide incentives for improvement to departments and clinicians.

The Safety Office also undertook several projects to improve our communication to both inside and outside constituencies. At the national level, the first ever multidisciplinary undergraduate elective was created for credit in the Colleges of Nursing, Medicine, Applied Health, and the School of Public Health. The faculty was drawn from around the country and included Senator Barack Obama's chief physician advisor. Tim McDonald, David Mayer and Bill Chamberlin traveled to Washington, D.C. to meet with her and provide advice on potential national legislation concerning safety. Focus on scientific presentations was also undertaken as the group participated in the Safety and Quality Forum for the University HealthSystem Consortium in 2006. Our solution to the retained instrument problem was presented at the 18th annual International Health Institute meeting. Drs. McDonald and Mayer also direct an annual meeting in Telluride, Colorado focused on teaching medical schools to teach safety.

Continued advances are planned for 2007. The Patient Safety Collaborative is in the planning process to gain Institute status. This would provide an excellent platform to launch efforts at educating professionals across America on the lessons learned at UIC as we strive to improve the care of our patients.