Reported to the Board of Trustees September 12, 2013

# Safety and Risk Management Report September 2013

The "Seven Pillars" Comprehensive Process for the Prevention and Response to Patient Harm

The nationally-recognized University of Illinois Hospital (UIH) Seven Pillars program, run by the Department of Safety and Risk Management under the Division of Quality & Patient Safety, continues to focus on all seven of the critical elements across the University of Illinois Hospital & Health Sciences System (UI Health) including

- 1.) event reporting
- 2.) rapid and effective communication following harm
- 3.) interdisciplinary investigation
- 4.) waiver of hospital and professional fees when care is deemed inappropriate
- 5.) performance and process improvements
- 6.) data analysis, and
- 7.) education.

The Department continues to track these elements and focus on linkages between effective communication and malpractice claim reduction in conjunction with University Risk Management in Urbana.

## UIH Data – January through June 2013

**Occurrence Reports** – There was a 5% increase in reporting near-misses and unsafe conditions as compared to the same timeframe in 2012 (from 3,128 to 3,244). This continues the sustained favorable trend of increased reporting since the Seven Pillars program was implemented in 2006.

**Investigation of Significant Events** – Root cause analysis associated with process improvements was conducted in the following areas:

- Management of food allergies
- Verification for sterilization of surgical instruments
- Management of critical addenda to test results.

**Communication Consult Service Support** – There was a 50% decrease in number of requests for Safety and Risk Management staff <u>to attend and facilitate</u> patient and family meetings involving communication of adverse events compared to the same time period in 2012 (from 29 to 14). Clinicians trained in the communication of adverse events are now managing this process independently or preparing for communications with coaching from the Department.

**Care for the Care Provider Support** – There was a 29% increase in the number of adverse event reports generating referrals for care provider peer-to-peer support over the same timeframe in 2012 (from 10 to 14).

**Staffing Effectiveness** – Review of staffing-related issues is continuously incorporated into the analysis of patient occurrences. The root cause analysis process includes assessment of task performance for each involved staff member with a Just Culture approach based on James Reason's Unsafe Acts Algorithm.

**Culture of Safety** – Planning for distribution of the Agency for Healthcare Research and Quality (AHRQ) Culture of Safety Survey this fall is in progress. Results will be compiled with a focus on assessment of staff effectiveness in the areas of teamwork and communication.

### **Patient Safety Initiatives and Process Improvements:**

- Revisions in the informed consent process for blood transfusions
- Ongoing evaluation of the use of telemetry

### **Research:**

**AHRQ grant** – The grant project has been extended through June 2014. Four members of the Department continue to engage in grant activity with ten Chicago area hospitals and are preparing to conduct a final gap analysis to assess the level of success in implementing the Seven Pillars process at all performance sites.

### **Education:**

**Graduate Medical Education** – The Department supports ongoing accreditation of Graduate Medical Education (GME) programs of physician residents, particularly in the areas of Quality and Safety education and in support of the Accreditation Council for Graduate Medical Education (ACGME) Clinical Learning Environment Review (CLER) Residency Program Accreditation Process that emphasizes the responsibility of the institution for assuring the quality and safety of the environment for learning and patient care.

Specifically, the Department of Safety and Risk Management will provide support to the accreditation process in assessment of patient safety occurrence reports submitted by resident physicians and facilitate their involvement in quality improvement efforts of the hospital. The six core areas include:

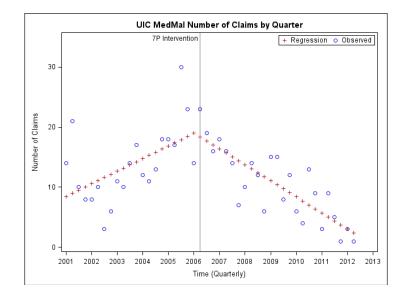
- **Patient Safety** opportunities for residents to report errors, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.
- **Quality Improvement** engagement of residents in the use of data to improve systems of care, reduce health care disparities, and improve patient outcomes.

- **Transitions in Care** effective standardization and oversight of transitions of care.
- **Supervision** maintaining and overseeing policies of supervision concordant with ACGME requirements in an environment at both the institutional and program level that assures the absence of retribution.
- Duty Hours Oversight, Fatigue Management and Mitigation processes to: (i) demonstrate effective and meaningful oversight of duty hours across all residency programs institution-wide; (ii) design systems and provide settings that facilitate fatigue management and mitigation; and (iii) provide effective education of faculty members and residents in sleep, fatigue recognition, and fatigue mitigation.
- Professionalism education focused on professionalism and monitoring behavior on the part of residents and faculty and responding to issues concerning: (i) accurate reporting of program information; (ii) integrity in fulfilling educational and professional responsibilities; and (iii) veracity in scholarly pursuits.

**Masters in Patient Safety Leadership** – Department staff continue to participate and develop experiential education for MPSL students. Newly developed program material focuses on a comprehensive approach to the study and implementation of the UIH Seven Pillars process and key elements of the program.

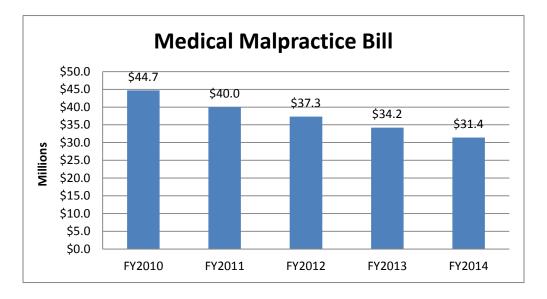
### Additional Support:

**Medical Malpractice** – The Department continues to maintain a detailed, frequently updated database of all medical malpractice claims involving University of Illinois employees within and outside the Hospital and Health Sciences System. As depicted by the graph below, since implementation of the Seven Pillars program in 2006, there has been a dramatic and sustained reduction in the frequency of claims against UI Health.



A number of factors have contributed to a reduction in the University's medical malpractice bill. These include positive litigation management and good trial outcomes overseen by University Counsel, a moderating of jury verdicts in Cook County, a softening of the commercial insurance market, positive investment returns in the self-insurance trust fund, full disclosure and rapid settlement in cases of clear medical error, and improvements to patient safety via the Seven Pillars program.

- The FY2014 medical malpractice premium is \$13.3 million less than FY2010.
- The FY2014 premium showed an 8.2% decrease over FY2013, and a 29.8% decrease over FY2010. (See graph below.)



• FY2014 self-insurance trust assets when compared to liabilities have gone from a negative \$44 million in FY2006 to a surplus of \$15 million in FY2014.

