

**Dear 2013 HOPE Award Selection Committee:**

I am writing to nominate my colleague, mentor, and friend Timothy B. McDonald, MD, JD, for the 2013 HOPE Award. Dr. McDonald is a Professor of Anesthesia and Pediatrics at the University of Illinois College of Medicine at Chicago and the Chief Safety and Risk Officer for Health Affairs for the University of Illinois. It is here at the University of Illinois Hospital and Health System (UIHHS) where Tim leads the patient safety efforts for the entire campus, hospital, and health system.

For more than a decade, Tim has dedicated his professional (and some of his personal) life to furthering the field of patient safety. His body of work has included such milestones as transforming undergraduate and graduate medical education to integrate safety and quality as core competencies, establishing an automatic peer-support effort system for physician and staff in the wake of unexpected patient outcomes, developed and co-led the first Illinois Board of Higher Education approved Institute for Patient Safety Excellence, personally championed and succeeded in efforts to have the patient-voice heard at every peer review, and along with his colleague Nikki Centomani, created, implemented, and sustained the Seven Pillars process for responding to unexpected adverse patient outcomes. It is Tim's work on the Seven Pillars process that I would like to highlight as a major achievement worthy of the prestigious honor of the MITSS HOPE Award.

The Seven Pillars process links effective and honest communication between patients and providers following patient harm events with improvements in patient safety, reduced medical liability risk, and improved timeliness of compensation for those who have been harmed<sup>1</sup>. At its core, the Seven Pillars is a mechanism for a health system to “do the right thing” for its patients, their families, and for the men and women who deliver care. It ensures that patients and their families are treated with respect and are not abandoned in the wake of a medical error. Early communication, often within thirty minutes of a harm event, is a hallmark of the program. This open and honest communication is not a one-time event but an iterative process initiated by both patients and the health system. The Seven Pillars process also allows for engaging patients and family members as partners in evaluating what went wrong and also in strategizing how to fix it. Notably, patients and family members sit on peer review boards, holding all health professionals and system leadership accountable for following through on promises to make the system better. As the Seven Pillars evolved, a care for the caregiver program was instituted. Here, the crisis management team automatically triggers support for caregivers after an adverse patient outcome. This support comes in many forms including peer support for physicians, coffee chats with associates, and if needed fitness for duty assessments to ensure the safety of both clinicians and patients.

The Seven Pillars process has been in place at the UIHHS since April 2006. Since that time, the system has seen a dramatic increase in occurrence reporting, an improvement in the number of peer reviews and process improvements leading to a learning culture, improved patient safety culture, a reduction in overall medical liability and risk, a decline

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<sup>1</sup> McDonald TB, et al. *Qual Saf Health Care*, 2010;19(6):e11. doi: 10.1136/qshc.2008.031633.

in claims, and a dramatically reduced time to settlement, getting financial remedies to the people who were harmed in a more timely manner. When we compared pre and post-implementation outcomes there was an observed significant post-intervention changes in mean quarterly number of incident reports (pre=479.3, post=872.5,  $p<0.0001$ ), patient communication consults (pre=0.5, post=12.0,  $p<0.0001$ ), peer reviews (pre=1.4, post=16.0,  $p<0.0001$ ), claims (pre=8.2, post=4.2,  $p<0.02$ ), legal expenses (pre=\$212,812, post=\$105,149,  $p<0.05$ ), legal fees (pre=\$255,096, post=\$44,012,  $p<0.001$ ), cost-per-claim (pre=\$278,980, post=\$124,281,  $p<0.05$ ), and settlement amounts (pre=\$3,461,321, post=\$2,055,675,  $p<0.05$ ). Implementing the Seven Pillars approach at the UIHHS improved the identification and capture of potential threats to patient safety, improved learning through increased peer review and process improvements, while significantly reducing the claims and costs associated with defending indefensible care.

For the past three-years, Dr. McDonald has led a team of researchers on a quest to implement and evaluate the impact of the Seven Pillars process on patient safety and medical liability outcomes at ten Chicago-land community hospitals. Early results suggest that the Seven Pillars can be effectively implemented with similar early results in non-academic health centers. While preliminary, the grant has demonstrated that not only is the Seven Pillars process adaptable to health centers with open medical staffs but that leadership, administration, and front line providers are ready and willing to engage in and adopt the process.

In summary, Dr. Timothy McDonald is an ideal candidate for the 2013 MITSS HOPE award. He embodies the mission and values of MITSS in supporting patients, families, and clinicians following adverse events, demonstrating respect for all groups and effectuating partnerships for learning and improving to make the health system safer for everyone.

Thank you for your kind consideration of this nomination,

Kelly M. Smith, PhD