

## More Hospitals Begin to Apply Lessons from Seven Pillars Process

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When the family of Michelle Malizzo Ballog found out that their daughter's 2008 death had been caused by a preventable medical error, one question trumped all others: How could this have happened?

To the family's surprise and relief, officials at the University of Illinois Hospital and Health Sciences System (UIHHSS) in Chicago did not defer that question to their lawyers. Instead, they investigated their suspicion that a fatal error occurred during Ms. Ballog's surgery, confirmed that information with the patient's family once it was established, apologized, and provided a financial settlement for Ms. Ballog's young children. Importantly, the hospital made changes in their anesthesia processes to ensure that the same error would not happen again.<sup>1</sup>

### *The Seven Pillars Process*

This approach, known as the "Seven Pillars," was adopted by UIHHSS in 2006. It is a notable exception in our nation's health care system, which still relies heavily on the medical liability system to sort out the myriad issues involved in investigating, addressing, and preventing patient safety events. (A full-disclosure policy that was adopted in 2001 by the University of Michigan Health System is credited with reducing costs per claim by 50 percent and earning approval of 98 percent of the system's faculty physicians.)<sup>2</sup>

Seven Pillars focuses on transparency to eliminate patient harm and learn from patient safety events. It includes:

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1. Patient safety incident reporting;
2. Investigation;
3. Communication and disclosure;
4. Apology and remediation, including waivers of hospital and professional fees;
5. System process and performance improvement;
6. Data tracking and performance evaluation; and
7. Education and training.

Over the 2-year period since its inception at UIHHSS, the process has led to more than 2,000 incident reports, prompted more than 100 investigations, and resulted in nearly 200 specific improvements. It has served as the basis for more than 100 disclosure conversations and 20 full disclosures of inappropriate or unreasonable care that caused patient harm.<sup>3</sup>

### *Expanding Seven Pillars to Other Hospital Systems*

But an important question remains: Can programs like Seven Pillars work outside of the contained environment of an academic medical center?

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To find out, the Agency for Healthcare Research and Quality (AHRQ) is funding a 3-year demonstration project in 10 Chicago-area hospitals with diverse organizational and ownership qualities. The grant, part of the Department of Health and Human Services' Patient Safety and Medical Liability Initiative, is being led by Timothy McDonald, a professor of anesthesiology and pediatrics and chief safety and risk officer at UIHHSS.

The 10 hospitals taking part in the Seven Pillars project reflect the diverse qualities of many U.S. hospitals. They are all private, self-insured organizations with open medical staffs and private professional liability coverage. Seven belong to faith-based systems, two are members of for-profit organizations, and one is located in an underserved inner-city location. Since the project began in 2010, two of the faith-based systems announced their intent to merge.

The comprehensive Seven Pillars intervention is currently under way in five hospitals; the other five hospitals will serve as a control group and begin reporting data in August 2012. The project is being rolled out in largely in the same way it works at UIHHSS, with specific training and protocols for reporting, communications, process improvements, and other key elements. A major difference, however, is that settlement offers may take longer to negotiate than they do at UIHHSS, where liability coverage includes the medical staff.

Preliminary data from the intervention hospitals show an increase in incident reporting and disclosures from physicians and residents, even in early settlement offers. One hospital has reported a significant decrease in serious safety events and open claims within 18 months. In cases where the hospitals have identified instances of inappropriate care, hospital and physician fees are being waived.

### ***Taking Improvements to Scale***

Although the final results of this demonstration project are still a year away, AHRQ is excited about its progress so far. And the Chicago area is not alone: the state of Maryland, the Wyoming Medical Society, and a group of Western states are determining how to roll out many elements of the Seven Pillars process. In Washington, DC, implementation of the program will begin at MedStar Health in October 2012.

From AHRQ's perspective, Seven Pillars incorporates much of what we believe is paramount to lasting gains in patient safety and quality improvement. First and foremost, it seeks to prevent patient harm by reporting—and correcting—flaws in processes that can undercut the work of the most dedicated clinicians. Second, the environment fostered by communication and disclosure builds respect and trust, which figure prominently in the well-being of patients and physicians. That trust is enhanced by substantial involvement of patient advocates in designing the study. Third, the Seven Pillars process establishes and reinforces a culture of learning, especially among medical residents who previously have had few opportunities to identify and learn from patient safety events.

This initiative also promises to fill an important gap: building additional evidence about the impact of alternative approaches to traditional medical liability on patient safety and quality. And, finally, based on the findings of the demonstration project to date, the Seven Pillars process can be replicated in other types of organizations. This may be the ultimate benchmark for determining the success of patient safety and quality-improvement efforts, and it is a benchmark that the Seven Pillars demonstration project appears to meet.

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## References

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**Note:** Authored commentaries in this IOM Series draw on the experience and expertise of field leaders to highlight health and health care innovations they feel have the potential, if engaged at scale, to foster transformative progress toward the continuously improving and learning health system envisioned by the IOM. Statements are personal, and are not those of the IOM or the National Academies.

In her commentary, Carolyn Clancy describes the promise offered by a systematic, seven-point process—the Seven Pillars process—to eliminate patient harm: incident reporting, investigation, disclosure, remediation, improvement, evaluation, and training. Her discussion touches on several issues and lessons central to the delivery of care that is effective, efficient, and continuously improving, including the importance of:

- Institutional leadership in implementing and supporting quality improvement efforts;
- Transparency in reporting, analyzing, and responding to errors, as well as in implementing system changes to prevent future similar errors; and
- Replicability of successful quality-improvement efforts in multiple, varying settings to ensure that lessons learned at one medical institution do not remain siloed, but instead benefit the broadest patient population possible.

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