

# SHINING A LIGHT

Safer Health Care Through Transparency



THE NATIONAL  
PATIENT SAFETY  
FOUNDATION'S  
**LUCIAN  
LEAPE**  
INSTITUTE

The National Patient Safety Foundation's  
Lucian Leape Institute  
Report of the Roundtable on Transparency

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*Shining a Light: Safer Health Care Through Transparency.*

We respectfully request that you take a few moments to complete a reader survey  
available online at: <https://www.surveymonkey.com/s/LLI2015>

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**Providing a strategic vision  
for improving patient safety**

THE NATIONAL  
PATIENT SAFETY  
FOUNDATION'S  
**LUCIAN  
LEAPE**  
INSTITUTE

## **The National Patient Safety Foundation's Lucian Leape Institute**

The National Patient Safety Foundation's Lucian Leape Institute, established in 2007, is charged with defining strategic paths and calls to action for the field of patient safety, offering vision and context for the many efforts under way within health care, and providing the leverage necessary for system-level change. Its members are national thought leaders with a common interest in patient safety whose expertise and influence are brought to bear as the Institute calls for the innovation necessary to expedite the work and create significant, sustainable improvements in culture, process, and outcomes critical to safer health care.



## **National Patient Safety Foundation**

The National Patient Safety Foundation's vision is to create a world where patients and those who care for them are free from harm. A central voice for patient safety since 1997, NPSF partners with patients and families, the health care community, and key stakeholders to advance patient safety and health care workforce safety and disseminate strategies to prevent harm. The Lucian Leape Institute is a key program within the NPSF portfolio.

NPSF is an independent, not-for-profit 501(c)(3) organization. Information about the work of the National Patient Safety Foundation may be found at [www.npsf.org](http://www.npsf.org).

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## EXECUTIVE SUMMARY

During the course of health care’s patient safety and quality movements, the impact of transparency—the free, uninhibited flow of information that is open to the scrutiny of others—has been far more positive than many had anticipated, and the harms of transparency have been far fewer than many had feared. Yet important obstacles to transparency remain, ranging from concerns that individuals and organizations will be treated unfairly after being transparent, to more practical matters related to identifying appropriate measures on which to be transparent and creating an infrastructure for reporting and disseminating the lessons learned from others’ data.

To address the issue of transparency in the context of patient safety, the National Patient Safety Foundation’s Lucian Leape Institute held two roundtable discussions involving a wide variety of stakeholders representing myriad perspectives. In the discussions and in this report, the choice was made to focus on four domains of transparency:

- Transparency between clinicians and patients (illustrated by disclosure after medical errors)
- Transparency among clinicians themselves (illustrated by peer review and other mechanisms to share information within health care delivery organizations)
- Transparency of health care organizations with one another (illustrated by regional or national collaboratives)
- Transparency of both clinicians and organizations with the public (illustrated by public reporting of quality and safety data)

One key insight was the degree to which these four domains are interrelated. For example, creating environments in which clinicians are open and honest with each other about their errors within organizations (which can lead to important system changes to prevent future errors) can be thwarted if these clinicians believe they will be treated unfairly should the same errors be publicly disclosed. These tensions cannot be wished away; instead, they must be forthrightly addressed by institutional and policy leaders.

In this report, the NPSF Lucian Leape Institute comes down strongly on the side of transparency in all four domains. The consensus of the roundtable discussants and the Institute is that the evidence supports the premise that greater transparency throughout the system is not only ethically correct but will lead to improved outcomes, fewer errors, more satisfied patients, and lower costs. The mechanisms for these improvements are several and include the ability of transparency to support accountability, stimulate improvements in quality and safety, promote trust and ethical behavior, and facilitate patient choice.

In the report, more than three dozen specific recommendations are offered to individual clinicians, leaders of health care delivery organizations (e.g., CEOs, board members), and policymakers.

If transparency were a medication, it would be a blockbuster, with billions of dollars in sales and accolades the world over. While it is crucial to be mindful of the obstacles to transparency and the tensions—and the fact that many stakeholders benefit from our current largely nontransparent system—our review convinces us that a health care system that embraces transparency across the four domains will be one that produces safer care, better outcomes, and more trust among all of the involved parties. Notwithstanding the potential rewards, making this happen will depend on powerful, courageous leadership and an underlying culture of safety.

## **SUMMARY OF RECOMMENDATIONS**

### ***Actions for All Stakeholders***

1. Ensure disclosure of all financial and nonfinancial conflicts of interest.
2. Provide patients with reliable information in a form that is useful to them.
3. Present data from the perspective and needs of patients and families.
4. Create organizational cultures that support transparency at all levels.
5. Share lessons learned and adopt best practices from peer organizations.
6. Expect all parties to have core competencies regarding accurate communication with patients, families, other clinicians and organizations, and the public.

### ***Actions for Organizational Leadership: Leaders and Boards of Health Organizations***

7. Prioritize transparency, safety, and continuous learning and improvement.
8. Frequently and actively review comprehensive safety performance data.
9. Be transparent about the membership of the board.
10. Link hiring, firing, promotion, and compensation of leaders to results in cultural transformation and transparency.

**Actions Related to Measurement*****Agency for Healthcare Research and Quality (AHRQ) and National Quality Forum (NQF)***

11. Develop and improve data sources and mechanisms for collection of safety data.
12. Develop standards and training materials for core competencies for organizations on how best to present measures to patients and the public.
13. Develop an all-payer database and robust medical device registries.

***Accreditation Bodies***

14. Work with the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Health Resources and Services Administration (HRSA) to develop measures of care that matter to patients and clinicians across all settings.

***Centers for Medicare and Medicaid Services (CMS)***

15. Require as a condition of participation in Medicare or Medicaid that all performance data be made public.

***All Parties***

16. Ensure that data sources are accessible to patients and the public, including claims data, patient registry data, clinical data, and patient-reported outcomes.

**Actions to Improve Transparency Between Clinicians and Patients: *CEOs, Other Leaders, Clinicians******Before Care***

17. Provide every patient with a full description of all of the alternatives for tests and treatments, as well as the pros and cons for each.
18. Inform patients of each clinician's experience, outcomes, and disciplinary history.
19. Inform patients of the role that trainees play in their care.
20. Disclose all conflicts of interest.
21. Provide patients with relevant, neutral, third-party information (e.g., patient videos, checklists) and expand the availability of such resources.

***During Care***

22. Provide patients with full information about all planned tests and treatments in a form they can understand.
23. Include patients in interprofessional and change-of-shift bedside rounds.
24. Provide patients and family members with access to their medical records.

***After Care***

25. Promptly provide patients and families with full information about any harm resulting from treatment, followed by apology and fair resolution.
26. Provide organized support for patients involved in an incident.
27. Provide organized support for clinicians involved in an incident.
28. Involve patients in any root cause analysis, to the degree they wish to be involved.
29. Include patients and families in the event reporting process.

30. Involve patients in organizational operations and governance.

**Actions to Improve Transparency Among Clinicians: CEOs and Other Leaders**

31. Create a safe, supportive culture for caregivers to be transparent and accountable to each other.
32. Create multidisciplinary processes and forums for reporting, analyzing, sharing, and using safety data for improvement.
33. Create processes to address threats to accountability: disruptive behavior, substandard performance, violation of safe practices, and inadequate oversight of colleagues' performance.

**Actions to Improve Transparency Among Organizations**

**CEOs, Other Leaders, Boards**

34. Establish mechanisms to adopt best safety practices from other organizations.
35. Participate in collaboratives with other organizations to accelerate improvement.

**Federal and state agencies, payers, including the Centers for Medicare and Medicaid Services (CMS), and liability insurers**

36. Provide the resources for state and regional collaboratives.

**Actions to Improve Transparency to the Public**

**Regulators and Payers**

37. Ensure that all health care entities have core competencies to accurately and understandably communicate to the public about their performance.
38. Ensure that health care organizations publicly display the measures they use for monitoring quality and safety (e.g., dashboards, organizational report cards).

**Health System Leaders and Clinicians**

39. Make it a high priority to voluntarily report performance to reliable, transparent entities that make the data usable by their patients (e.g., state and regional collaboratives, national initiatives and websites).



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## PREFACE

What if there were a magic pill that could fix many of the problems of patient safety, health care quality, patient engagement, and health care cost? What if this pill were relatively inexpensive and had a low incidence of side effects? What if this pill were available for use today? What if this pill attacked the problem through so many different mechanisms that the chance of the emergence of resistance was low?

There *is* such a magic pill. It is *transparency*—the free, uninhibited flow of information that is open to the scrutiny of others. It encompasses free information flow across four domains: transparency between clinicians and patients; transparency among clinicians themselves; transparency between health care organizations; and transparency between health care organizations and the public.\*

*Transparency: The free, uninhibited flow of information that is open to the scrutiny of others*

In this report, the fifth in the National Patient Safety

Foundation’s Lucian Leape Institute series of papers addressing central issues in patient safety, we lay out the case for transparency, a case we believe is both timely and powerful. Just consider the attributes of transparency:

**Transparency is relatively inexpensive.** While some costs may be incurred in building systems to support transparency and to educate clinicians, leaders, patients, and families, they will be offset by the considerable savings of costs now spent avoiding transparency.

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\*Throughout this paper, we use the term “clinician” for individuals who participate in direct patient care, such as physicians, nurses, medical assistants, pharmacists, respiratory therapists, and surgical technicians; we use the term “health care organizations” for organizations that participate in care delivery, such as hospitals, skilled nursing facilities, and physician practices.

**Transparency is an effective tool across the continuum of care.** In contrast to some other interventions, transparency can have powerful effects at all levels of the health care system: in inpatient and outpatient settings, for medical and surgical care, for care at the level of the individual patient and care that involves entire health care systems.

**Transparency works through multiple mechanisms.** Transparency improves quality and safety in a variety of ways: by improving trust between clinicians and patients, by improving communication among clinicians, by allowing clinicians to reap the rewards of their strong performance while providing information to others that allows them to emulate the best practices, by enabling patients to evaluate their care and make informed decisions about where to seek care, by opening up systems for additional scrutiny (such as by accreditors or journalists), and by leveraging the potent human emotions of pride and competition. Effective improvements at different leverage points are likely to have a synergistic effect.

**Transparency supports the basic principles of professionalism.** Transparency is consistent with and reinforces clinicians' views of professionalism: to put the patient's interests first and to ensure quality care. Although clinicians generally want to share information to improve patient care and safety, doing so is often impeded by a variety of barriers that currently exist.

**Transparency is generally a welcomed tool.** Patients, families, and policy-makers uniformly welcome transparency in health care. As evidenced by ProPublica's recent Voices of Patient Harm project, patients and family members strongly desire transparency.<sup>1</sup> On the provider side, the American Hospital Association and American Medical Group Association have also argued for the principle that transparency should drive quality efforts.<sup>2-3</sup>

Unlike virtually all other safety interventions tried to date, the results of transparency efforts—at all levels of the system—have consistently been *better* than expected, both in terms of improved performance and fewer “side effects.” For example, hospital performance on so-called Core Measures markedly improved after the Centers for Medicare and Medicaid Services (CMS) began reporting clinical data on its “Hospital Compare” website,<sup>4</sup> and rates of early elective cesarean sections plummeted after implementation of a strategy of transparency and payment reform.<sup>5</sup> Similarly, public reporting of patient experience data has led to major improvements, with many hospitals, clinics, and individual clinicians making substantial efforts to improve performance.<sup>6-7</sup> In fact, there is little evidence that the addition of pay-for-performance, a much more complex and fraught intervention, works better than simple transparency.<sup>8</sup>

Studies at the University of Michigan have demonstrated that rapid disclosure of adverse events, accompanied by honest explanations and, where appropriate, fair and timely settlement offers is highly satisfying to patients and clinical staff alike and ultimately leads to lower malpractice settlements for clinicians and their institutions.<sup>9</sup> Moreover, giving patients full access to their medical records has been associated with strikingly high levels of acceptance by clinicians and patients, as well as patient-reported improvements in self-care.<sup>10</sup> In sum, in forms ranging from public reporting of data at the national policy level to breaching the culture of medical secrecy at the level of the individual patient, transparency is both the right thing to do and an effective way to improve the health care system, in every domain and across the entire care continuum.

While transparency is powerful, it is not entirely free of potential side effects. Like any strong medication, it needs to be given by competent institutions and clinicians, and patients need to understand how it works. It requires an appropriate environment to support its use. And it must be used safely. Everyone—clinicians, leaders, patients, payers, and policymakers—must be confident that the data being shared are scientifically valid and accurate.

Clinicians need assurances that they will be treated fairly by the system after being transparent.

If transparency *were* a drug, it would likely be a

blockbuster, given the evidence of its effectiveness and its enthusiastic endorsements from key stakeholders. Yet transparency today is one of the most underused vehicles to improvement in our health care system. It is easy to understand why: a number of complex, intrinsic barriers inhibit its use. These barriers must be identified and removed if we are to take full advantage of the power of transparency. We are confident that the effort to do so will pay off many-fold—in improved health, improved health care, and the return of trust to the relationships among clinicians, patients, and the institutions in which care is delivered.

***Transparency is both the right thing to do and an effective way to improve the health care system, in every domain and across the entire care continuum.***

## INTRODUCTION

Nearly 15 years after an Institute of Medicine (IOM) report launched the modern patient safety movement, harm from medical care continues at unacceptable levels.<sup>11</sup> Recent studies have shown little progress in reducing the toll from medical errors.<sup>12–15</sup> By some estimates, the number of deaths from mistakes each year is *higher* than the 44,000 to 98,000 figures that so galvanized the public in 1999.<sup>16</sup>

In addition to clinical harm, the US health care system also receives failing or barely passing grades in several other key dimensions, including reliability, quality, patient experience, and access.<sup>17</sup> Moreover, the system is buckling under the costs of care, with more and more patients responsible for paying greater proportions of such costs. A recent article in the *Journal of the American Medical Association* argued that our system must focus on doing “no (financial) harm.”<sup>18</sup> These costs are not just financial; unnecessary and low value care is a significant source of morbidity and mortality as well.

Many of the proposed solutions for patient safety that have been tried over the past 15 years have been less successful than one would have expected, or have had unanticipated negative consequences. The most effective intervention has probably been the use of checklists, but even checklists are ineffective if not accompanied by a supportive culture and clinician engagement.<sup>19–20</sup> Other highly touted solutions, including education programs, computerization, efforts to improve organizational culture, root cause analyses, and payment changes, have had some impact on patient safety, but there is clearly much room for improvement.

We believe the missing ingredient, the essential element needed to enable the operational and culture changes to occur, is transparency. Why do we care about transparency? There are four fundamental reasons:

- To promote accountability
- To catalyze improvements in quality and safety
- To promote trust and ethical behavior
- To facilitate patient choice

From the public policy perspective, transparency is essential for accountability. Without full information, neither policy makers nor patients can know whether clinicians and their organizations are delivering safe, appropriate, cost-effective care.

From the quality and safety perspective, transparency is foundational for learning from mistakes and for creating a supportive environment for patients and health care workers. Transparency of all safety, quality, and cost data is also essential to the effective functioning of the health care delivery system. To make informed and cost-effective decisions, all stakeholders—patients, clinicians, payers, providers, and policymakers—need to have full information in a form that is useful and understandable. If health care systems and clinicians don't know about failures, they can't fix them.

Not only does transparency promote accountability and improvement, but it lies at the heart of the relationship between a patient and his or her clinician. How can patients fully trust the clinicians and organizations from which they receive care if these clinicians and organizations are not fully transparent?

Without transparency, informed choice is impossible for either patients or payers. Without full, honest, open communication, patients cannot make informed decisions about their care or manage the resulting emotional and physical challenges when things go wrong. Moreover, transparency identifies best performers, allowing them to reap the rewards of their strong performance and allowing others to emulate their best practices. Patients have a right to full information about every aspect of their care. Without it, optimal care is an elusive dream.

Transparency is a necessary first step to improving care, but alone it is insufficient. Transparency must be used with the goal of improving care, not simply to expose flaws or previously hidden information. Transparency is a precondition to the accountability required to honestly and directly acknowledge gaps and errors—the first step to addressing the problems that lead to patient harm. Transparency must be

combined with the will and resources to act on data by identifying gaps and deficiencies, redesigning care processes, and ultimately improving patient care and outcomes.

Although our focus in this report is on transparency with safety data, we believe there is tremendous value in full transparency of cost data, including unit and procedure costs, charges, and reimbursements; costs within institutions, between institutions, by each reimbursement agent; costs incurred in network, out of network, and in public, private, and nonprofit entities—in short, any and every line item that can appear on a billing statement. Full

transparency with these data would be a major step forward in helping consumers make informed choices, especially if these data were coupled with quality information. However, a full discussion of

transparency in cost data is beyond the scope of this report. Therefore, we will only address cost data where it is relevant to safety and quality.

***Every stakeholder in the health care system, including patients and clinicians, suffers the consequences of the current lack of transparency. Opacity of information represents a missed opportunity to prevent harm to patients.***

We recognize that increasing transparency will represent a major culture change for most institutions. Success requires strong leadership as well as extensive education and training, changes in infrastructure, and support at all levels to maximize the benefits of transparency and minimize the potential harms.

Although many will embrace the concept of transparency, when it comes to actually applying it, individuals and institutions often become overwhelmed by fear and inertia. The prospect of revealing previously confidential or hidden information and adopting new attitudes and practices is daunting. Clinicians and institutions themselves are frequently unaware of the data; its collection for the purposes of transparency is a revelation in and of itself. Yet case after case has shown that if this fear can be overcome, transparency works better than people had hoped and is less risky than they had anticipated.

Despite the evidence of its effectiveness and its enthusiastic endorsements from key stakeholders in the health care system, transparency has been largely overlooked as a patient safety tool.<sup>4,9–10,21–22</sup> Every stakeholder in the health care system, including patients and their clinicians, suffers the consequences of the current lack of

transparency. Deliberate withholding of information because of exaggerated fears and self-interest places patients at risk. Conscious decisions to frustrate transparency represent a moral failure. This is the future state for which we must strive: a health care environment in which no patient is harmed because of the withholding of information or the failure to sound an alarm when practices are found to be substandard.

Because of the foundational position and complexity of transparency, the National Patient Safety Foundation's Lucian Leape Institute convened experts with a wide range of expertise and a variety of perspectives for two roundtable meetings. The group was tasked with scrutinizing the role of transparency in health care and considering ways to promote it. The group focused on the topic of transparency in relation to patient safety, but it also considered examples of transparency in other realms, such as quality outcomes, the patient experience, and (to a limited degree) costs, from which lessons might be applied to patient safety.



## OVERARCHING BARRIERS TO ACHIEVING TRANSPARENCY

At first glance, the benefits and importance of transparency may seem obvious. Free access to and sharing of information is both a practical necessity for optimal patient care and a moral imperative to prevent the same risk of harm to others. Accreditation bodies require health care organizations to report data on specific quality and safety measures, which are then shared publicly.<sup>21</sup> However, transparency in health care is about much more than public reporting, and significant barriers exist to achieving it at all levels, including concerns about patient privacy, the integrity of shared data, the burdens of collecting and analyzing data, and medical liability.

Achieving transparency in health care requires an in-depth understanding of its complexities. This understanding must encompass the risks, possible downsides, and barriers to achieving transparency, as well as subtle nuances in implementation, such as the need for skill, support, and sensitivity when disclosing harm to patients.<sup>23</sup>

Four barriers are especially powerful: fears about conflict, disclosure, and potential negative effects on reputation and finances; the lack of a pervasive safety culture and the leadership commitment needed to create it; stakeholders with a strong interest in maintaining the status quo; and the lack of reliable data and standards for reporting and assessing clinician behavior regarding transparency.

**Fears about conflict, disclosure, and potential negative effects on reputation and finances.** Fear is a significant barrier to achieving transparency. By their nature, humans avoid conflict. Clinicians fear having their errors made visible and worry about potentially negative effects of disclosure on their professional reputation and financial security. They are understandably concerned about damage to their livelihood or privileges, losing their licenses, being reported to the National Practitioner Data Bank, or simply experiencing humiliation or shame about perceived mistakes. The highly litigious climate in the United States fuels these concerns, as does a lack of training about the benefits of disclosure.<sup>22</sup>

**The lack of leadership and organizational will to create a culture of safety.**

The absence of a pervasive culture of safety in many health care organizations is a significant barrier to transparency. In fact, without transparency it is not possible to have a culture of safety. Creating a safety culture is a prime responsibility of an institution's leader. If the organizational governance and leaders fail to commit to transparency by building the systems and structures required to support it, the efforts of those at lower levels of the organization will be undermined. Without the needed emphasis by leaders, clinicians and managers may not have (or sense that they do not have) dedicated time for transparency-related activities.

In addition, organizations without a pervasive culture of safety may be less likely to hold clinicians and leaders accountable for being transparent and fail to provide the necessary training for clinicians in how to disclose information (particularly to patients) effectively. Leaders in organizations that lack a safety culture may fail to see the business case for transparency and may not recognize that transparency can catalyze improvements in other realms.

**Stakeholders with a strong interest in maintaining the status quo.** A variety of stakeholders have a strong interest in maintaining the status quo regarding transparency in health care, which may derail attempts at improvement. To protect their financial, reputational, and other interests, some parties—including clinical leaders, industry and legal representatives, and health care administrators—may resist the sharing of information.

**Lack of reliable definitions, data, and standards for reporting.** Another important barrier to transparency is the lack of reliable and accepted metrics for patient safety. One contributing factor is the complexity of medical conditions and treatment, which may make it difficult to differentiate errors from the complications of diseases or therapies. In addition, unreliable data sources hinder complete transparency. Sound metrics that really matter to patients and clinicians are in short supply in the safety arena, especially across the continuum of care. Even where there are sound metrics, the measurement process may be onerous. Finally, measurement overload caused by multiple data reporting requirements can prevent clinicians from prioritizing the actions that foster transparency.

These overarching barriers block progress in all four of the domains of transparency. However, the domains differ in several respects, including specific barriers, benefits, and the roles and responsibilities of stakeholders in achieving transparency. Understanding the unique characteristics of each domain is essential to fostering transparency and effecting real change in patient safety.



## THE FOUR DOMAINS OF TRANSPARENCY

We define four distinct yet overlapping domains of transparency. These categories reflect the groups or individuals among whom the free flow of information is required in order for there to be substantive improvement in patient safety. Two are internal, functioning within the organization: transparency between clinicians and patients, and transparency among clinicians; and two are external, pertaining to how health care organizations relate to one another: transparency among institutions and public reporting.

The four domains of transparency are interrelated. If the environment is not supportive of clinicians reporting and discussing their errors, it will be difficult for them to be open and honest with their patients, and unlikely that errors will be reported, analyzed, and shared within the organization or with other organizations. A genuine tension exists between the need for transparency to patients and the need for a protected space in which clinicians

can discuss and report errors. For example, unbridled requirements for public reporting, such as requirements to link specific events with

*The four domains of transparency are interrelated. For example, unbridled requirements for public reporting may dampen the willingness of clinicians to disclose errors and adverse events.*

individual clinicians, may dampen the willingness of clinicians to disclose errors and adverse events to patients and their organizations. In the ideal world, transparency would be complete among all parties. Today, however, we may need to retain some protected space, carefully balancing these needs while we move aggressively toward the ideal.

The true promises of transparency in each domain can best be portrayed through a description of the expected patient experience and an explicit commitment to truth telling on the part of clinicians.

## Transparency Between Clinicians and Patients

**Patient's expectation:** I understand all aspects of my care.

**Clinicians' commitment:** We are honest with our patients and their families about all aspects of care; we disclose and apologize for our mistakes; and we take responsibility for improvement to prevent future mistakes.

### **Benefits of Transparency Between Clinicians and Patients**

- Improved care experience for patients and families
- Ability to engage in effective shared decision making
- Avoidance of adversarial situations between patients and clinicians
- Consistency between messaging and behavior
- Elimination of the disruptive consequences of litigation
- Reduced legal fees

Transparency between clinicians and patients can be defined as: extreme honesty with patients and their families from start to finish. The span of honesty includes shared decision making, fully informed consent before treatment, free and open communication during the process of care, and openness with patients and families when things go wrong. This domain of transparency is a key element of patient engagement, as described in the report *Safety Is Personal: Partnering with Patients and Families for the Safest Care*, published by the NPSF Lucian Leape Institute in 2014.

Shared decision making is the process in which a fully informed patient discusses his or her preferences and values with the clinician, who in turn provides unbiased information about the benefits and risks of all of the various testing and treatment options tailored to that patient.<sup>24–25</sup> Fully informed consent includes a complete and balanced discussion of all aspects of the proposed care, including the potential benefits and risks (i.e., outcomes) of all alternatives. For each alternative treatment or procedure, patients should be provided the available information on the degree of risk, the probability of each potential outcome, and a realistic idea of what they are likely to experience during and after the treatment or procedure.

Transparency during the process of care includes having all clinicians and trainees identified by name, title, and experience or training level, and fully informing the patient of the plans and the rationale behind all aspects of diagnosis and treatment. It also includes openness during care, such as the transparency achieved by bedside rounding with patient and family participation.

When care results in complications or unexpected outcomes, the appropriate response is prompt acknowledgment of the event to the patient and family and attention to the patient's new clinical needs. What is known about what happened should be explained, coupled with a promise to investigate to determine the causes of the event and to communicate the findings to the patient as soon as possible.<sup>26-27</sup> To ensure complete data collection and full transparency, the investigation should include interviews with the patient and family.

After the investigation is completed, the responsible clinician(s) should offer the patient and the family a full explanation of the findings and tell them whether the adverse event is a result of failures in care or the unfortunate but unpreventable complication of an intervention or condition. While empathy is crucial in both circumstances, when patient harm results from failures in care, the responsible clinicians and administrators should promptly apologize to patients and their families and move quickly to address the consequences.

Some organizations, such as the University of Michigan Health System and the University of Illinois Medical Center at Chicago, have made strides in this area by embracing apology, disclosure, and early resolution initiatives.<sup>22</sup> (For an example of how transparency between clinicians and patients can work in a real-world setting, see Case Study 1 in the Appendix.)

Notwithstanding the ethical imperative to be open and honest, the current status of transparency between clinicians and patients in most organizations is less than optimal. Organizational leaders may not yet know how best to promote transparency with patients and families. For example, should the organization disclose all nonharmful errors? Should patients and families be involved in root cause analyses of events that occurred during their own care? While we recommend involvement of patients and families in root cause analyses, if they are willing, we believe these topics are worthy of continued discussion and experimentation and should be subjected to rigorous empirical research in order to better understand the benefits and harms of different approaches.

The principles of transparency should also be applied to the informed consent process. Clinicians have a tendency to present more benefits than risks when discussing proposed treatments or procedures, especially for interventions in which they personally have expertise or emotional investment or, in some cases, financial self-interest. To the degree feasible, such conflicts of interest should be disclosed to patients and families. Conflicts of interest have become an area of greater focus and transparency since the requirements of the Physician Payment Sunshine Act were released in 2013. The legislation requires that drug, device, and biologicals manufacturers report on

payments and items of value given to physicians and teaching hospitals. The data are publicly available on the CMS website ([www.cms.gov/openpayments](http://www.cms.gov/openpayments)).

Patients need to be transparent as well. Clinicians cannot prescribe appropriate and effective therapy if patients withhold important information about their condition and behavior (such as use of illicit drugs). To encourage such disclosure, clinicians must create an environment of trust and support so that patients feel safe to talk about sensitive issues.

The rationale for improving transparency in this domain is unambiguous. Clinicians have a moral obligation to ensure that patients and families fully understand risks before agreeing to an intervention and that they have access to the truth about their care experience. Openness with patients and their families is an integral aspect of good care and is the cornerstone of the trust that is essential for the patient to be fully engaged in his or her health care. Clinicians and patients also need closure after an adverse event, which cannot happen without an open and honest discussion. From an organizational perspective, the processes that provide transparency with patients and families also identify opportunities for improvement, which can then be addressed.

Not only is the rationale for greater transparency between clinicians and patients compelling, the interest in transparency is both strong and growing. Several million individuals currently have access to at least some of their clinicians' notes.<sup>28</sup> A recent pilot study found that a patient's review of the medication list in his or her record was helpful in identifying errors. About one third of patients in the study opted to provide online feedback; of these 89% requested changes to the medication list. In almost 7 of 10 cases, the pharmacist made one or more changes to the list based on the patient's feedback.<sup>29-30</sup> Full transparency between clinicians and patients requires that patients have unfettered access to their entire medical record. As an ethical imperative and to ensure safety, patients need to know past and current treatment plans, test results, and other data contained within their record. They also need full access to review the record for accuracy and amend any incorrect information. To ensure meaningful accessibility to the records, the medical record must include tools to translate technical terminology into language that patients can understand.

Although meaningful use requirements set forth in the Health Information Technology for Economic and Clinical Health (HITECH) act of 2009 call for clinicians to give patients timely access to some of their health information (e.g., lab results, problem list, medication lists, known allergies), they do not require the sharing of clinicians' notes.<sup>31</sup> We believe this aspect of transparency should become the standard of care in the future.

A prerequisite for complete openness with patients and families is full leadership support. As one roundtable participant stated, “We need courageous leaders to take bold action and put a high priority on disclosures and actions that support transparency.” Boards and organizational leadership must take the lead in making transparency a priority and creating a culture that supports it, in part by making it safe for those who regard such honesty as risky. Mid-level managers must also be key promoters of transparency in order for full adoption to penetrate the front lines. For more information on the relationship of organizational culture to patient safety, see the NPSF Lucian Leape Institute report *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care* (2013).

**Barriers to Achieving Full Transparency Between Clinicians and Patients**

- Clinicians’ fears about litigation, reputation, and financial status
- The fee-for-service system incentive to favor procedures over other treatments
- Clinicians’ discomfort with conflict and difficult conversations
- Patient fears about damaging relationships with their clinicians
- Failure to make time for honest conversations
- Pressure from risk managers and legal consultants to withhold information
- Clinicians’ mistaken belief that he or she is already transparent with patients
- Limited use of measures (surveys) to hold clinicians accountable for transparency
- Difficulty distinguishing preventable harm from an expected complication
- The prevalence of health illiteracy and innumeracy
- Lack of emphasis on transparency with patients in medical and nursing education
- Lack of training, tools, and coaching in shared decision-making and disclosure
- Lack of leadership focus on transparency
- Conflicts of interest

## Transparency Among Clinicians

**Patient's expectation:** My clinicians communicate with each other about my care.

**Clinicians' commitment:** We communicate with other clinicians about the care we deliver in order to improve coordination and consistency of care and to prevent errors.

### **Benefits of Transparency Among Clinicians**

- Correction of omissions and gaps in the clinical record
- Sharing of best practices among clinicians
- Reduction in shame and sense of isolation among clinicians after an incident
- Fewer redundant diagnostic tests and imaging, leading to a reduced risk of complications, fewer false positive results, lower costs, and greater efficiency

The second form of transparency is the sharing and open communication of information about hazards, errors, and adverse events among clinicians in order to improve systems of care. The ability of clinicians to report and discuss errors without fear of punishment or embarrassment is a precondition for transparency in this domain. Leaders and boards must create and maintain a “just culture.” In a just culture, delivery organizations seek to understand and fix system flaws, recognizing that even competent clinicians make mistakes. At the same time, in a just culture, there is no tolerance for reckless behavior. In other words, individuals are held accountable for gross misconduct and conscious disregard of risks to patients; they are not held accountable for flaws in the system itself.<sup>32–33</sup>

Although there are examples of collaborative groups of stakeholders openly sharing quality- and cost-related data, transparency regarding safety remains the exception rather than the norm. The majority of frontline clinicians are not currently sharing data to an extent that would be optimal for patient safety. Safety reporting only identifies a small percentage of adverse events and near misses that occur. In addition, even if clinicians on a given clinical unit discuss safety events or data points in a daily huddle, this information is not consistently shared with other units within the organization.

Traditional morbidity and mortality meetings do not generally fulfill their potential usefulness in improving patient safety, especially where they fail to generate thorough root cause analyses and lessons learned, and where the learning tends to be

siloed in specific departments. In addition, these meetings typically provide only a partial analysis of the event because they fail to include clinicians from every discipline on the care team, or the patient's point of view. Internal quality and safety reports are often de-identified, presumably to protect clinicians, but this can also inhibit opportunities for learning and sharing. Clinicians should know how their performance compares to their colleagues so they can learn, improve, and spread best practices (e.g., a surgeon who becomes aware of a higher infection rate for his patients compared to colleagues should have the opportunity to learn from those colleagues). A nonpunitive culture where this kind of learning is supported is critical.

Similarly, asking clinicians to “police” each other has proven to be ineffective in achieving the identification and reporting of behavior that is disrespectful, unprofessional, or substandard. Too often clinicians, aware that a colleague is practicing in a substandard or even harmful manner, fail to speak up because of a tradition that considers not criticizing colleagues as consistent with professionalism, as well as the “glass house effect” of fearing that they will be targeted. This is unethical and unacceptable. Medicine's claim to special privilege as a profession is based on society's understanding that it will always put patients' interests first.

Silence can also be deadly if clinicians fail to speak up when colleagues do not use evidence-based practices in their work (e.g., handwashing). Clinicians have a responsibility to put the interests of patients before their own; this applies to all patients—not just their own, but also their colleagues'. In an ethical culture there is no place for protecting colleagues at the expense of patients.

Finally, organizations and individual clinicians must avoid using peer review activities as a means for avoiding harmful discovery in the event of legal action. Organizational leaders must avoid invoking privileges related to peer review to skirt accountability and avoid the changes needed to improve the safety and reliability of care.

Some organizations are finding ways to encourage and enable transparency among clinicians. For example, at Nationwide Children's Hospital in Columbus, Ohio, clinicians engage in multidisciplinary “huddles” after any adverse drug event, talking openly about issues and learning from each other about possible causes and interventions.<sup>34</sup>

***Barriers to Achieving Transparency Among Clinicians***

- Clinicians' desire for a protected environment to discuss adverse events
- Lack of expertise in root cause analysis
- Failure to provide feedback from root cause analyses to frontline clinicians
- Confusion about the ideal unit for reporting (individual clinician versus the team)
- Confusion between the “no blame” approach to errors and holding clinicians accountable for following safe practices
- The professional culture of protecting colleagues
- Debate about the amount of evidence needed before implementing an intervention
- Difficulty in creating a culture where sharing of individual data drives learning and improvement rather than shame

Fostering greater transparency among clinicians requires decisive action by leadership; clinicians cannot effect these changes alone. First and foremost, leaders and boards must build a culture of safety and ensure that data are shared at front lines of care by taking specific steps that support transparency. Effective leaders often begin executive and board meetings with a patient story to emphasize the importance of transparency. They look for ways to reinforce the importance of patient and employee safety to the organization, such as displaying on the staff intranet system the number of days since the last sentinel event and the last employee injury. They demonstrate their willingness to achieve transparency by holding weekly safety walkrounds (although such rounds need to be embedded in a positive and open learning culture to add value) and open meetings for all employees to discuss specific safety events.<sup>35</sup>

Second, transparency among clinicians requires that leaders establish effective mechanisms for identifying safety events, such as internal reporting of safety events, data extraction from electronic health records (EHRs), walkrounds data, chart review, and other sources. Leaders must ensure that frontline clinicians have a protected process for reporting patient safety concerns, and robust mechanisms for analyzing these concerns, implementing improvement, and providing feedback. In addition, there should be multiple mechanisms for providing feedback to clinicians, including peer observation; coaching on interpersonal, technical, and cognitive skills; and routine review of individual clinicians' complication rates, utilization of tests and procedures, and length of stay for inpatient care. Review of utilization data is important to patient safety, because it can identify areas of potential harm and misuse of resources that can contribute to harm.

Finally, effective leaders hold clinicians accountable for their behaviors and actions. They ensure that clinicians conduct and share the results of root cause analyses. They communicate the philosophy that every specific event reflects a series of problems that may cause harm in the future if not addressed. They use data to start conversations with clinicians who receive low scores on safety-related metrics or have received unsolicited complaints from patients, families, or staff. They establish a culture in which the expectation is to report concerns about a colleague rather than covering it up. Such leaders create a fundamental cultural transformation in which sharing among clinicians is encouraged, facilitated, and rewarded. The goal is to use transparency not just to hold people accountable, but for learning and improvement.

## Transparency Among Organizations

**Patient's expectation:** My care system shares and receives information to improve care for me and for others.

**Organizations' commitment:** As learning organizations, we continually strive to improve the care we provide by sharing information and learning from our peers.

### **Benefits of Transparency Among Organizations**

- Benchmarking to accelerate improvement
- Sharing of best practices
- Ability to apply lessons learned from an error at another organization, to prevent similar events
- Reduction of redundant diagnostic tests and imaging

The third domain of transparency relates to the open sharing of safety data among health care organizations, including hospitals, payers, vendors, and purchasers. Barriers to achieving transparency in sharing data among health care organizations are the significant cultural shift required to overcome resistance to open sharing, lack of interoperability of electronic health records, and fear of litigation or loss of peer review protection.

A well-known example of the perils of not sharing information across organizations comes from Virginia Mason Medical Center, where patient Mary McClinton died after receiving an injection of chlorhexidine, an antiseptic solution, instead of intravenous contrast dye. Analysis of the event revealed a series of mistakes, including the placement of filled syringes, which had a similar appearance, on the procedure prep table.<sup>36</sup> Later it was discovered that the same chlorhexidine-related error had occurred previously at another organization nearby, but there was no mechanism to share such information across organizations. By failing to share events and best practices, we increase the likelihood that the same safety events will continue to happen over and over again.

Transparency among organizations *can* work. Collaboratives—which consist of organizations that commit to testing new practices within a specific topic area, then measuring and sharing results and lessons learned—have advanced transparency in this domain. (To read about an example of a successful collaborative, see Case Study 2 in the Appendix.) Unfortunately, this kind of open sharing among organizations is not widespread.

Patient safety organizations (PSOs) represent another mechanism for advancing transparency among organizations. PSOs are federally listed groups established to collect, analyze, and aggregate patient safety data. To address the fear of increased risk of liability with reporting, communications with PSOs and the reports they create are protected. According to the Agency for Healthcare Research and Quality (AHRQ), there are currently 84 federally listed PSOs in 31 states and the District of Columbia.<sup>37</sup> PSOs have the potential to foster transparency through increased reporting of complications and errors, and identification and sharing of learning and best practices; however, it remains to be seen how successfully these groups can balance the need for a protected space to which organizations can voluntarily report errors and the need for open sharing of information outside the organization.

Transparency among organizations is not limited to hospitals and health systems. Competitors need to learn to better share data and not compete on safety, akin to what the airline industry decided to do years ago. One promising example is the ECRI Institute's Partnership for Health IT Patient Safety, which is convening patient safety organizations, clinicians, vendors, associations, researchers, and other experts to discuss safety issues arising from health information technology and to share best practices to mitigate risk.

***Barriers to Achieving Transparency Among Organizations***

- The lack of strong CEO and board support for achieving transparency
- Resistance to giving competitors an advantage in the marketplace
- Concern about malpractice litigation
- Lack of incentives to allocate resources to the creation and maintenance of registries
- Lack of trust in PSOs
- Uncertainty about how to influence behavior once outliers are identified
- Uncertainty about how to measure safety effectively
- Lack of understanding of the regulations governing PSOs
- Clinicians' desire for protected space versus the need to share experience for learning

We believe the concerns about the risks of transparency among organizations, most notably regarding litigation, are exaggerated, and that increased collaboration will be associated with tangible positive results. We acknowledge that a certain degree of courage is required on the part of leadership to carry an organization “over the hump,” allowing it to enjoy the benefits of transparency, and we call upon organizational leaders to demonstrate such fortitude.

Storytelling is a powerful tool for inspiring change. Stories about organizations that have navigated the shift to greater transparency allow clinicians and leaders to identify with their peers and to understand what transparency in action looks like. Stories help individuals to embrace the rationale that underpins transparency and to become motivated to adopt new attitudes and practices. A crucial part of transparency is having an organization become comfortable in telling its own stories—including both positive stories and adverse experiences—to both internal and external audiences.

## Transparency to the Public

**Public's expectation:** I can easily access information about health care that is valuable to me.

**Organization's commitment:** Our organization is committed to sharing timely, accurate information about the care we provide, in a way that is useful to our patients.

### **Benefits of Transparency to the Public**

- Ability to compare organizations and clinicians and select based on quality, safety, and cost
- Ability for patients to make care decisions that are truly informed
- Greater patient trust in clinicians and organizations
- Motivates providers to accelerate internal quality improvement efforts

This fourth domain involves the public reporting of harmful events, as well as making available reliable data on other aspects of safety. Like the other types of transparency, this domain requires a protected environment and a safety culture to encourage full reporting.

Public reporting represents what many people think of when they consider the concept of transparency in health care. Public reporting has increased substantially since the publication of *To Err Is Human*, but many states still don't even require reporting of "never events," and few states require reporting of other types of important safety data. A limitation to improving this situation is that the methods used to collect data are sometimes flawed, so there has been a shortage of credible data that are relevant for consumers.

Until recently, the only major data source available to support public reporting has been claims data. Since they are not collected for safety assessment but for payment purposes, claims data are limited in content and utility. In addition, the validity of claims data has been challenged because some clinicians and health care organizations have manipulated them (e.g., upcoding) to maximize revenues. These issues are being addressed by CMS. Now that the data are being used for quality and safety reporting as well as payment, there are incentives on all sides to make them more accurate and complete. Penalties for submitting fraudulent claims data and auditing mechanisms are now much stronger. Professional attestation is also required in some instances. A report released in May 2014 by the President's Council of Advisors on Science and Technology underscores the importance of increasing access to health-related data. One of the six goals put forth by the council focuses on increasing the availability of data to enable improved population health management, foster research, and inform clinical care.<sup>38</sup>

In addition, over the past decade there has been a rapid increase in the adoption of new payment models and health plans by health systems, employers, and other public and private sector purchasers of health care (e.g., bundled payments, accountable care organizations, high-deductible health plans). These new models are escalating consumer demand for health care transparency by creating a new breed of price-conscious consumers, who in turn also want information about the quality of the services provided. Indeed, when making choices about hospital selection, safety issues have been shown to be more important to consumers than cost.<sup>39</sup>

The rapid growth in the use of EHRs should also allow for more timely and accurate collection of meaningful safety data, which may then in turn fuel transparency programs. However, most current iterations of EHRs are inadequate for this purpose, and many place a significant data collection burden on clinicians. It will take time to make the modifications needed to address these issues.

In 2000, public reporting at the national level began when employers formed The Leapfrog Group to voluntarily collect safety data from hospitals. Since then, much effort has been devoted to bringing crucial safety data to the public's attention, especially through groups such as Leapfrog and publications such as *US News and World Report* and *Consumer Reports*. These groups have been critical in creating greater transparency with the public and providing information that was previously unavailable. However, because these programs may use various methodologies to assess a variety of safety and quality data, the results sometimes appear to be conflicting.

Many websites also exist to assist patients in identifying high-quality clinicians (e.g., Healthgrades.com, CalQualityCare.org), although the information may not be to the level of detail that patients need. Greater attention must be paid to understanding which measures are of value to patients and how to present the data in a useful and meaningful way. With the support of the Robert Wood Johnson Foundation and others, a number of regional health improvement collaboratives have formed across the country to gather and publicly report data of interest to local communities, and to help the lay public make sense of the rating systems that exist. We must do a better job at educating the public and the media about the clinical importance, relevance, limitations, and best use of publicly reported measures used to assess the safety performance of organizations, practice groups, and individual clinicians.

Another key issue related to public reporting is the significant financial impact of ratings or marks on health systems or clinicians. Both individual clinicians and organizations stand to lose revenue if negative outcomes are publicly displayed. Conversely,

achieving and marketing a “Best Of” rating can boost both revenue and reputation, providing a strong incentive to control or block the open sharing of relevant, accurate performance data. On the other hand, financial pressure for higher performance is a market phenomenon well known to drive quality improvement in other industries, and it is creating enormous opportunity for health systems. Moreover, in an era where consumers are more price-conscious and are “shopping” for services, withdrawing from public reporting is an increasingly risky strategy for a health system worried about protecting market share. Consumers do not respond well to evidence that providers are declining to provide data publicly.

A few organizations have courageously taken steps to report publicly without being asked. After a careful, slow approach, the University of Utah now publicly posts reports on individual clinicians regarding the patient experience. While clinicians may have been discomforted by this initiative, posting does not appear to have been detrimental to the organization; according to early reports, the performance of the health system against national measures of patient satisfaction has risen steadily in the years since implementation.<sup>6,40</sup> The University of Michigan publicly reports the results of its patient safety culture surveys, and some health systems have reported candidly about errors or accidents that galvanized transformation, such as Virginia Mason’s very public and forthright discussion of the tragic death of Mary McClinton. (To learn more about how an organization implemented transparency with the public as well as in the other three domains, see Case Study 3 in the Appendix.)

#### ***Barriers to Advancing Transparency to the Public***

- Fear that publicly displayed ratings will harm reputation, income, and market share
- Reluctance to be among the first to carefully track safety data, as these may show higher rates of adverse events than competitors’ data show
- Obstacles to transparency by lobbyists representing various financial interests
- Shortage of data that are relevant and credible to the public
- Measurement fatigue for clinicians from collecting the large amount of data required
- Lack of a national database to facilitate sharing of safety-related information
- Lack of a federal mandate for accurate collection and reporting of safety data
- Lack of robust measures for assessing and reporting safety events
- A low frequency of serious safety events at the individual or organizational level
- Lack of understanding of which measures matter to the public

Although significant barriers exist to transparency in each domain, a number of powerful levers exist as well. Our recommendations are based on our recognition of the importance of these levers.

***Levers to Advance Transparency***

- Strong organizational leadership at the board and CEO levels
- Measuring the extent of pretreatment conversation between patient and clinician
- Mandating public disclosure by CMS or accreditation bodies
- Data-based competition among organizations
- Formal education about transparency in medical, nursing, and business schools
- Coaching clinicians about the effective response after an unexpected outcome
- Organization culture change (e.g., Virginia Mason’s Respect for People initiative)<sup>41</sup>
- Payment incentives or purchasing pressure from large employers
- Expanded availability of comparative safety information for consumer choice
- Identification of outliers and sharing data to inform patients and for improvement
- Use of safety data by payers and employers when making purchasing decisions
- Tying payment to compliance with transparency requirements
- Use by CMS of its purchasing leverage to obtain care information for the public
- Development of valid safety metrics across the continuum of care
- Tracking and publishing the fatalities that result from preventable medical harm

***Strong leadership and a supportive culture of safety are preconditions for transparency and must be in place before other action steps will be effective.***

## CALL TO ACTION: RECOMMENDATIONS FOR CHANGE

Achieving transparency at all levels in health care is a daunting task. It will require effort from all stakeholders: CEOs and leaders of health care organizations; doctors, nurses, and other clinicians; government agencies and regulators; private organizations; payers; and many more. We set out here the recommendations of the NPSF Lucian Leape Institute Roundtable on Transparency for action around common concerns and in each of the four domains discussed earlier.

### **Actions for All Stakeholders**

1. Ensure disclosure of all financial and nonfinancial conflicts of interest.
2. Ensure patients have access to reliable, unbiased information presented in a form that is useful to them.
3. Consider carefully the perspective and needs of patients and families when displaying or presenting data.
4. Create and maintain organizational cultures that are supportive of transparency at all levels.
5. Share lessons learned and adopt best practices from peer organizations where feasible.
6. Expect all clinicians, organizational leaders, and board members to have core competencies regarding accurate and truthful communication with patients, families, other clinicians and organizations, and the public.

### **Actions for Organizational Leadership**

*Transparency is an essential element of a supportive culture of safety. Strong leadership that models honesty and prioritizes transparency is a prerequisite for effective change in this arena. Without courageous leaders and boards willing to emulate and prioritize transparency in every domain within their organizations, other actions are unlikely to achieve meaningful success.* (For more information on the importance of leadership in creating the cultural norms essential for an environment that is safe and

supportive of transparency, see the NPSF Lucian Leape Institute report *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care*, 2013.)

Ensuring a culture of safety, in which the focus is on improving systems to prevent harm rather than blaming individuals for human error, is a prerequisite for full reporting of safety-related events and effective learning-oriented discussions to improve safety. The need to create a safe, supportive environment for reporting and discussing safety may at times be in tension with the need for widespread external reporting of errors and adverse events. Health care leaders and board members must acknowledge and reconcile this tension and provide a safe environment to foster the optimal sharing of information among all transparency domains.

Strong leadership is essential for establishing and maintaining a culture of safety and for prioritizing transparency at all levels of the health care organization. Leaders and boards set the expectations for behaviors related to disclosure and apology, reporting of errors, and learning from adverse events.

***We call on leaders and boards of all health care-related organizations*** (including hospitals, clinics, drug and device manufacturers, insurers, and payers) to:

7. Prioritize transparency and a culture of safety and continuous learning and improvement.
8. Frequently and actively review comprehensive safety performance data.
9. Be transparent about the membership of their boards.
10. Measure the cultural transformation and transparency performance of leaders and tie results to their periodic evaluations (i.e., in relation to hiring, firing, promotion, and compensation).

## **Actions Related to Measurement**

*Improving the quality of existing safety measures and the current state of transparency (and tracking meaningful improvement over time) is essential to advance transparency.*

***We call on the Agency for Healthcare Research and Quality (AHRQ) and the National Quality Forum (NQF)*** to:

11. Develop and improve data sources and mechanisms for collection of safety data. This will require improvements in health information technology (HIT) systems, processes within health care delivery organizations, and the training and credentialing of clinicians.
12. Develop standards and training materials for core competencies for organizations on how best to present measures to patients and the public, and education to the public and media about the utility and limitations of these measures.

13. Develop an all-payer database and robust medical device registries. Creating a federally supported database to include claims from all health care payers would help ensure that safety-related data are collected in a standardized manner and allow for the cross-organizational comparisons required for patient safety. Industry-supported databases are subject to conflicts of interest that could undermine their usefulness in achieving transparency. Unique patient identifiers would ensure privacy while improving the accuracy and utility of entered data.

In addition, information from medical device registries should be regularly delivered to all stakeholders, including the public. Governmental agencies should support the use of publicly available registries. (For more information, see the Pew Trust report *Medical Device Registries*.<sup>42</sup>)

***We call on groups that play a role in accreditation of health care organizations to:***

14. Work with the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Health Resources and Services Administration (HRSA) to develop measures of care that matter to patients and clinicians across all settings.

***We call on the Centers for Medicare and Medicaid Services (CMS) to:***

15. Require as a condition of participation in Medicare or Medicaid that the full range of performance data be made publicly available in a timely manner. At a minimum this would include claims, registry, and accreditation data (e.g., survey and other accreditation data from national accreditation bodies).

***We call on all parties to:***

16. Ensure that data sources are accessible to patients and the public, including claims data (regardless of payer), patient registry data, clinical data, and any patient-reported outcomes.

## **Actions to Improve Transparency Between Clinicians and Patients**

*Patients and families have the right to transparency and partnership with clinicians throughout the entire continuum of care. Clinicians have an obligation to facilitate discussion with patients and their families in a way that patients and families can understand and that leads to their fully informed participation and decision making.*

***We call on the CEOs and leaders of all health care institutions and their clinicians to establish mechanisms and support to ensure the following for all of their patients:***

### ***Before Care***

17. Provide every patient with a full description of all of the alternatives for tests and treatments, as well as the pros and cons for each (i.e., patients engage in a shared decision-making process with their clinicians).
18. Inform patients of each clinician's experience, outcomes, and disciplinary history.

19. Inform patients of the role that trainees play in their care.
20. Disclose all conflicts of interest.
21. Provide patients access to relevant, neutral, third-party information when available; expand the availability of such resources (e.g., patient videos, checklists).

#### ***During Care***

22. Provide patients with full information about all planned tests and treatments in a form they can understand.
23. In the inpatient setting, include patients in interprofessional and change-of-shift bedside rounds and reporting (ideally with scheduled rounds at predetermined times).
24. Provide patients and family members with access (both as inpatients and in the ambulatory setting) to their medical records (e.g., via OpenNotes).

#### ***After Care***

25. Promptly provide patients and families with full information about any harm resulting from treatment, followed by apology and fair resolution.
26. Provide an organized support structure and counseling for patients involved in an incident.
27. Provide an organized support structure and counseling for clinicians involved in an incident.
28. Involve patients, families, and patient representatives in any adverse event review or root cause analysis, to the degree they are willing and able to be involved.
29. Include patients and families in the event reporting process.
30. Involve patients, families, and patient representatives in organizational operations and governance (e.g., membership on committees).

It is essential that patients be involved in the reporting and investigation of adverse events, as well as the subsequent improvement efforts. Their input is vital to identifying flaws and improvement opportunities in current processes.

### **Actions to Improve Transparency Among Clinicians**

*All members of the care team must feel that they can openly and honestly share information with each other.*

***We call on the CEOs and leaders of all health care organizations to:***

31. Create a safe, supportive culture for the members of the care team to be transparent and accountable to each other.
  - a. Reward transparency and create consequences for not speaking up.
  - b. Create and enforce policies for safe reporting of errors.

32. Create multidisciplinary structures for reporting, analyzing, sharing, and using safety data for improvement.
  - a. Develop standard processes to ensure robust analysis, follow-up, and feedback of safety-related issues identified from a variety of sources (e.g., safety reporting, morbidity and mortality conferences, walkrounds).
  - b. Provide forums to share individual performance data among clinicians and facilitate opportunities to improve practices.
33. Create structures and processes to ensure accountability and professional responsibility.
  - a. Develop processes to address disruptive behavior and substandard individual performance (e.g., 360 reviews).
  - b. Establish consequences for misconduct, such as deliberate unjustified violation of safe practices.
  - c. Establish mechanisms for effective professional oversight of colleagues' performance.
  - d. Address obstructions to transparency. Many powerful individuals and organizations benefit from the current lack of information flow and resist attempts to achieve transparency. The lobbying efforts and other obstructive actions of these stakeholders must be called out and addressed.

### **Actions to Improve Transparency Among Organizations**

*Boards and leaders of every health care organization (including hospitals, industry, vendors, payers, and others) have the obligation to share reports of safety events, share solutions, and implement best practices in a timely manner.*

***We call on the CEOs, leaders, and boards of all health care organizations to:***

34. Establish CEO and board-endorsed internal infrastructures in health care organizations to identify, adopt, and sustain relevant patient safety best practices from other organizations.
35. Participate in collaborative learning environments to accelerate improvement among health care organizations (e.g., new innovative models including some patient safety organizations that identify and communicate about adverse events and share best practices).

***We call on federal and state agencies, payers, including the Centers for Medicare and Medicaid Services (CMS), and liability insurers to:***

36. Provide the resources and incentives to establish frameworks for collaborative learning so institutions can learn from one another how to improve.

## **Actions to Improve Transparency to the Public**

*The public has the right to have access to key data on patient safety, quality of care, conflict of interest, and costs from all parties in health care, including delivery systems, clinicians, government, payers, and vendors (e.g., drug and device companies). All valid, relevant data that the patient would want to know should be made available in forms that are accessible and understandable to the patient.*

***We call on state and federal regulators and all payers*** to establish mechanisms to:

37. Ensure that all entities within the entire health care system have core competencies to accurately and truthfully communicate to the public about their performance in a way that the public understands.
38. Ensure that health care organizations publicly display the metrics that they monitor (e.g., board dashboards, organizational report cards) and that indicate their level of transparency.

***We call on health system leaders and clinicians*** to:

39. Make it a high priority to voluntarily report their performance to reliable, transparent entities that make the data usable by their patients (e.g., state and regional collaboratives, national initiatives and websites).



## CONCLUSION

The free, uninhibited flow of information—transparency—is an essential requirement for patient safety, a tool for achieving greater safety, and a measure of the professionalism and ethics of clinicians and their organizations. Transparency is currently lacking in the US health care system in all four domains: between clinicians and patients; among clinicians; among organizations; and in the external environment through public reporting. These gaps must be addressed to achieve comprehensive, meaningful improvement in patient safety. We urge all stakeholders to embrace this challenge and take immediate actions to facilitate the free flow of information that will ultimately improve the safety of patients in all health care settings.



## APPENDIX: CASE STUDIES OF BEST PRACTICES IN TRANSPARENCY

### Case Study 1: Transparency Between Clinicians and Patients

#### **Apology and Disclosure: Advancing Transparency at the University of Michigan Health System**

Founded around a medical school that opened in 1850, the University of Michigan Health System (UMHS) has long been at the cutting edge of scientific research and clinical care. In 2001, UMHS took a bold step forward in advancing patient safety by launching a novel program for responding to medical errors. The program's cornerstone is honesty and open communication, with a focus on balanced assessment and communication of the reasonableness of care and disclosure of any fault. Richard Boothman, JD, chief risk officer at UMHS, describes the idea behind the Michigan Model as: "Reach out to those harmed, be honest, explain where appropriate, disclose our mistakes, and learn from our experiences."

#### **Implementing the Michigan Model**

Boothman began implementing the approach that became the Michigan Model soon after accepting the position as assistant general counsel at the organization. His initial forays into convening open conversations with patients about errors were not warmly embraced by all leaders within the health system and general counsel's office. However, clinicians who had experienced Boothman's approach were strongly supportive, and the program was formalized. "The caregivers saw that it was the right thing to do. And once they actually had *permission* from a lawyer, honesty came naturally for most, reminding them why they became physicians in the first place," he says.

According to Boothman, although open communication about errors with patients and families is the thrust of the approach, the first disclosure is among the clinicians and administration within the organization. UMHS uses a number of strategies to identify possible medical errors, including patient complaints, reports from clinicians, and regular reviews of patient safety metrics. When an unanticipated outcome is identified, risk managers contact the patient and family, ensure appropriate care is provided, and facilitate open and honest dialogue. The patient and family are invited to a conversation with clinicians about the event, receive an apology when warranted, and, where indicated, are offered financial compensation when appropriate for injuries that have occurred during the provision of medical care. Data and findings related to the case are entered into the organization's patient safety and peer review systems.

### **The Rewards of Transparency**

Although many leaders and clinicians were initially concerned that full disclosure about errors would invite more claims and larger settlements,<sup>43</sup> the opposite has been the case. A study of the claims and costs at UMHS found a significant reduction in both the average monthly rate of new claims and the average monthly cost for liability.<sup>9</sup>

The Michigan Model has demonstrated a number of compelling, nonfinancial benefits for injured patients and their clinicians. According to Boothman, these benefits are more compelling than the monetary ones. "The financial benefits in medical malpractice claims of the Michigan Model pale in comparison to the safety and quality benefits. Specifically, the value of the resulting culture of openness transcends that of the decreased number and cost of claims." The ability to openly discuss the specific details of a case—which is effectively stopped short with litigation—allows timely closure for all involved. Patients and families are not left wondering about the specifics of what happened. They are given an opportunity to ask questions about the events that occurred and a chance to understand, rather than guess at, the underlying causes. Clinicians have an opportunity to apologize and express their regret. Disclosure has moral benefits within the organization and beyond. "We've learned that when you act ethically, you tend to pull everyone up, too," says Boothman.

Finally, full transparency with patients promotes clinical improvement by encouraging the discovery of problems so that they can be proactively addressed. "Importantly, we've learned what accountability feels like—and though that doesn't always feel very good . . . that discomfort drives us and leaves us confident that we will improve our care, not just our excuses," Boothman explains. Full transparency allows clinicians, executives, and the organization as a whole to learn from an

adverse outcome and address flaws in care processes to improve the safety of future patients. The resulting culture has fueled remarkable progress in peer review and led to innovative changes in corporate structure, all toward serving a greater sense of accountability at every level.

***Disclosure with Patients: A Case Vignette***

Boothman describes a particular anecdote to illustrate the process of disclosure with patients at UMHS.

The patient, JW, was a 36-year-old school teacher, a wife, and the mother of two young children. She initially approached her primary care physician with concern about a breast lump. Her physician discounted its importance and failed to pursue the problem with appropriate testing. When breast cancer was eventually diagnosed, the mass was removed with clear margins, but there had been a two-and-a-half-year delay in treatment.

JW underwent surgery and chemotherapy. She became depressed and felt unable to return to work, despite being deemed physically capable by her oncologist. Boothman invited JW, her attorney, and the clinicians involved to a meeting to discuss openly the details of the case, including a fair means for compensating JW for the delay in diagnosis. Among the topics discussed was the risk of recurrence. JW had previously believed her risk was relatively high, a belief based on clinical trial statistics from the existing literature base and exaggerated by experts hired by her attorney. Hearing her concerns, a medical oncologist was able to reassure her that the often quoted statistics were primarily based on studies conducted before the current treatments were available, and that JW's prognosis was better than she had believed. The oncologist also encouraged her to return to work, pointing out that JW had no need to avoid working and was an invaluable asset to her children and the students in her classroom.

The atmosphere in the meeting shifted with this exchange. JW shared that she regretted that she had not pressed more firmly for diagnostic testing when she first discovered the lump. According to Boothman, at that moment the breast surgeon reached out, touched her hand, and said, "Stop blaming yourself. This is on us."

In the end, the parties agreed to a settlement chosen because it would provide for college and graduate schooling for JW's children. The hospital also video-taped an interview with JW and promised to use it for educational purposes.

According to Boothman, what JW wanted most was not financial; it was an open conversation about her care and its flaws, a chance to ask questions and to share her own feelings of regret, and an honest apology from her clinicians. As

she described her feelings about the meeting in the video recording, “I felt like I had been heard, they listened. . . . If that had been the end of the legal pursuit, that would have been fine with me. I was perfectly satisfied after that night.”<sup>44</sup> The videotape of her story has been used within UMHS to educate clinicians, residents, and students. JW returned to work and remains a UMHS patient.

### **Lessons Learned: Small Steps and Growing Comfort with Transparency**

In the course of implementing the disclosure program, UMHS learned two key lessons about transparency. First, it was important for the organization to take small steps when initially moving into full disclosure. Creating a protected space within the organization to discuss errors was essential for crossing the emotional hurdle to disclosure outside the organization. Gaining confidence and experience only emboldened expansion of disclosure, which, with time, has led to true culture change.

Second, UMHS learned that the historic concerns about transparency were exaggerated. As the organization made the transition to full disclosure and open conversations with patients, clinicians and leaders found that the previously feared horrific outcomes did not materialize. “We made the difficult disclosure to ourselves when we hurt patients in preventable ways—and we discovered that it wasn’t so bad,” Boothman says. With growing comfort with disclosure, clinicians and leaders began to appreciate the benefits of transparency and were increasingly less concerned about possible negative consequences resulting from being fully honest with patients and families about errors.

## **Case Study 2: Transparency Among Organizations**

### **Wisconsin Collaborative for Healthcare Quality: Reaping the Benefits of Data Sharing**

Founded in 2003, the Wisconsin Collaborative for Healthcare Quality (WCHQ) began as a joint endeavor of health care organizations and purchasers in the state of Wisconsin to improve the quality of health care in the state by coordinating the collection and sharing of performance data. Previous efforts to track and improve the quality of care had been hampered by a number of barriers, including payer-specific data collection and analyses that relied solely on claims-based data to assess quality, which excluded Medicare, Medicaid, and self-pay patients, and thus limited data accuracy and the reach of improvement initiatives. Efforts were also slowed by a lack of buy-in from clinicians because of concerns about the relevance and validity of

existing performance measures. The lack of consistency regarding physician attribution also blocked advancement because it undermined the assurance of accurate results.

Recognizing the sensitivity inherent in the collection and sharing of performance-related data, the nine founding members, which included hospitals, health systems, and physician groups in Wisconsin, chose to focus initially on trust building within the group. In late 2002, member representatives began meeting to discuss goals, expectations, and potential areas of agreement. The group met for an entire year to establish trust and identify a shared vision and goals.

Working together, physicians, data analysts, and quality specialists from WCHQ member organizations developed measures to assess the quality of both hospital-based and ambulatory care. The Collaborative also commissioned the development of a repository-based data submission (RBS) tool that many member organizations continue to use to ensure secure submission of patient-level global data files. The process allows claims, clinical, and patient-related data to be collected, regardless of payer type. WCHQ analysts, under the guidance of the physician-led Measurement Advisory Committee, validate that data and measures are consistent with evidence-based standards.

Beginning in 2003, member organizations started sharing unblinded performance data of group practices (not individual clinicians) within their organizations. In 2004, WCHQ began posting performance data at the group level on its website ([www.wchq.org](http://www.wchq.org)). Currently, data are displayed at the medical group and clinic site level. Site-level reporting requires a minimum of three clinicians per clinic.

### **Collecting and Publicly Reporting Quality Metrics**

The Collaborative collects and publicly reports on a variety of metrics with the majority being either process or outcome measures of ambulatory care clinical quality. Examples of specific metrics include process measures, such as cancer screening, immunization, and tobacco cessation counseling, and outcome measures, such as blood pressure, hemoglobin A1C, and cholesterol levels for patients with diabetes. In 2005, WCHQ added some cost metrics, such as an all-payer adjusted charge for inpatient cardiac care. Data are collected from two specialty registries for public reporting: The American College of Cardiology and the Society of Thoracic Surgeons. The group also assesses the patient experience via specific measures for physician groups. CGCAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems) data were recently publicly reported for the first time in June of 2013. Hospitals submit and publicly report their inpatient data separately via the Wisconsin Hospital Association.

Because data from all payers are included, the Collaborative allows member organizations to assess performance across their entire patient population. Members who report using the RBS system have the ability to run custom reports at any desired frequency and use the customized data reports internally so that practitioners can monitor and launch improvement initiatives. Collaborative-wide data are used to identify and share best practices from higher-achieving organizations. WCHQ has the ability to submit data on behalf of members utilizing RBS for CMS initiatives such as the physician quality reporting system and meaningful use, and currently reports for more than 2,700 physicians in Wisconsin.

In addition to providing data repository and reporting services, WCHQ facilitates work groups to foster performance improvement and convenes Collaborative-wide bi-monthly learning events to share valuable lessons and best practices.

### **Improving Performance**

Approximately half of all patients in the state are cared for by physician groups that participate in WCHQ.<sup>45</sup> Collaborative members initially tended to be larger practices within integrated delivery systems or multispecialty physician practices within tertiary care hospitals; more recently smaller primary care practices have joined WCHQ.

Since organizations began submitting data and sharing unblinded results within their practices, there have been significant improvements in performance among Collaborative members. A 2013 study that reviewed data from the first five years of the Collaborative's public reporting found that its members improved significantly on ambulatory care measures and that all physician groups improved on most of the measures.<sup>45</sup> For example, for 15 of 16 physician groups the rate of breast cancer screening improved; the average rate of improvement was 0.07, which was statistically significant. In comparison with non-WCHQ physician groups in the state and across the country, groups participating in the Collaborative have significantly higher rates for the majority of ambulatory care measures.

WCHQ data have provided a valuable resource for better understanding the factors that facilitate performance improvement. A survey of 409 primary care clinics within WCHQ confirmed that implementation rates of appropriate diabetes interventions had increased in the period from 2003 to 2008.<sup>46</sup> In addition, the study found that member groups that focused on metrics related to diabetes were significantly more likely to implement one or more diabetes interventions than groups that lacked this focus.

**Identifying Key Success Factors**

When asked to identify key success factors of the Collaborative, its president and CEO, Chris Queram, points to the upfront time spent in trust building. “In exchange for the investment of time to develop trust, the group has been able to accomplish profound changes in a relatively short amount of time.”

Queram also points to the strength of the physician leadership from member organizations and the collaborative environment within the local culture. These components were essential to the development of trust, which was a prerequisite for achieving transparency.

In addition, Queram believes that the voluntary nature of participation in the Collaborative was essential to its success. He asserts that the free sharing of data would have been impossible if participation had been mandatory. However, he acknowledges that because participation is voluntary, not every physician group participates, which is a source of frustration at times for purchasers and customer advocates. Queram believes that barriers to participation, such as a lack of dedicated quality improvement staff or information systems capable of easily capturing data, may lessen over time. With the advent of financial incentives that tie reimbursement to outcomes, Queram believes that smaller practices and other nonmembers may choose to join.

Despite the Collaborative’s focus on quality rather than safety metrics, Queram believes that many of the lessons learned are directly applicable to the sharing of safety data among clinicians. Most important, WCHQ members learned that trust building and creating a shared vision for the way in which stakeholders work together were critical. The group also learned that patient-level data must be used for the resultant analysis to be most actionable and that timely and accurate data are indispensable for engaging physicians in conversations about improvement. Finally, Collaborative members learned that physician champions are needed within each service line to address physician resistance regarding transparency.

The Collaborative work groups are currently considering metrics to add to the database, such as total cost, total resource use, and patient safety measures. The Collaborative is also working to facilitate affinity groups of members that are focused on a similar short-term goal to share best practices and accelerate performance improvement.

### **Case Study 3: Transparency in All Four Domains**

#### **Children’s Hospitals in Ohio: Commitment to a Compelling Vision**

In the 1980s, six children’s hospitals in the state of Ohio formed a collaborative, the Ohio Children’s Hospital Association (OCHA), to share common interests including negotiating with state officials about reimbursement and regulatory issues related to pediatric health. The participating hospitals received between 40 and 60% of their revenue from Medicaid and thus were highly affected by state reimbursement decisions. In the mid-2000s, the group began to consider expanding its mission to care quality and safety, but members were hesitant because of concerns about sharing performance data and whether the data might be misused. One member organization was able to encourage and guide the group, having come through the cultural change required for broad sharing of safety data and full transparency with patients and their families.

#### **Prioritizing a Commitment to Improvement**

In the late 1990s, Cincinnati Children’s Hospital (CCH) underwent a number of organizational changes, including the hiring of a new CEO, James Anderson, and creating a revised vision statement: “To be the leader in improving child health.” These changes paved the way for the hospital’s first quality improvement project, which was the use of care protocols to manage asthma, bronchiolitis, and fever of unknown origin for pediatric patients in the emergency department (ED). Hospital leaders were well aware that if the protocols were successful in improving care management in the ED, there would likely be a significant reduction in hospital admissions and a resultant loss of revenue. Despite the possible negative financial consequences, the hospital chose to move ahead with the project.

Anderson sums it up this way: “We took the stance that we didn’t want to build our business model on services that weren’t needed. Instead, we wanted to focus on providing services that add value.” By implementing the care protocols, the hospital reduced admissions for these conditions by 30% to 50%.<sup>47</sup> According to Anderson, the embracing of these improvement projects reflected the “institutional support for radical change to take better care of kids even at the expense of reduced revenue.” Interestingly, the hospital’s revenue actually *increased* by 15% during the period of time the protocols were implemented, as freed-up bed capacity allowed the organization to accept more admissions for more complicated conditions. These conditions were reimbursed at a higher rate than the three for which admissions declined.

### **An Impetus to Improve Public Reporting**

In 2001, CCH was one of seven organizations across the country to receive a Pursuing Perfection grant from the Robert Wood Johnson Foundation. The grant provided financial support for performance improvement, to which the organization was committed, but it also required full transparency with patients as a condition for its acceptance. With initial concern and then growing confidence, the organization began publicly reporting safety data on its website, including the rates of surgical site infections and ventilator-associated pneumonia, mortality rates, and other data. In addition, the organization began posting on its intranet the number of days since the last serious safety event and the last employee lost-time accident, emphasizing to employees the organization's commitment to safety. Over time, the culture of the organization shifted to one that strongly valued patient and employee safety and transparency.

### **A Commitment to Transparency Between Clinicians and Patients**

The commitment of CCH to transparency with patients was tested in 2001, when data from the Cystic Fibrosis Foundation showed that CCH—previously believed to be among the top in the country—actually ranked at the 20th percentile for cystic fibrosis (CF) care. According to Anderson, organizational leaders were anxious about revealing this information to the parents of patients with CF, but pressed forward because of their commitment to the organizational vision of being the leader in child health.

The hospital called a meeting of the parents, shared the data, and offered to assist them in finding care elsewhere, if they desired. Alternatively, if the parents elected to stay with CCH, they could help the organization improve. All of the families chose to stay at CCH.<sup>48</sup> The organization applied best practices gleaned from top CF centers in the country and radically changed CF care. Today, the program consistently achieves key performance goals of cystic fibrosis care (e.g., relating to lung function and nutritional status) that are well above the national average and is ranked within the top five pediatric hospitals in the United States for pulmonary care.<sup>49–50</sup>

### **Addressing Communication to Improve Transparency Among Clinicians**

As part of the Pursuing Perfection initiative, CCH began assessing ways to increase communication between clinicians and individual patients and their families about their care. They began a program of rounding with family involvement, and they monitored feedback from all involved parties, including nurses, residents, attending physicians, and family members. Based on the feedback, they modified the process and within a year had implemented family-focused teaching rounds throughout the hospital.<sup>51</sup>

In addition, the hospital is part of the multi-site I-PASS Study initiated in 2010 that is assessing ways to improve information handoffs between clinicians. The study involves the implementation of a standardized process, called the I-PASS Handoff Bundle, for communication between clinicians to reduce errors. A study of the project demonstrated a 30% reduction in medical errors, as well as lower rates of verbal and written miscommunication.<sup>52</sup>

### **Building Trust to Improve Transparency Among Organizations**

The experience with transparency and the existing safety culture at CCH helped pave the way for the OCHA members to follow the experience of CCH and embrace transparency among themselves for data coming out of shared safety initiatives.

Initially, according to Anderson, there was little enthusiasm at the board level of OCHA member hospitals for initiatives that could adversely affect the hospitals' financial status. With time, however, executives at the hospitals made the case for participation and the boards gave their consent. The group began by convening a meeting of the chief executives, medical officers, and nursing officers from the six hospitals for a presentation by a patient safety expert from Seattle Children's Hospital. As a result of the meeting, the group selected metrics and processes for managing an improvement plan.

In 2005, the group began its first initiative: a project to eliminate preventable cardiac and cardiopulmonary arrests, or "code blues," outside of intensive care units (ICUs). A significant barrier at first was the concern of each hospital about sharing safety data with competing organizations. Executives were wary that competitors might use the disclosed data to their own marketing advantage and were worried about the potential effects on their organization's reputation in the marketplace. Anderson found that this barrier was effectively removed with a series of conversations with the other executives, during which he described the experience of CCH and reiterated the goal of "standing together for improved care for kids."

Eventually, the group began sharing data and best practices. By using transparency and working together, the hospitals achieved an average reduction of 46% in code blues outside the ICU. According to Anderson, the initiative was a huge breakthrough for the group in that it displayed the willingness and ability of competing hospitals to work together to collectively improve patient safety. "Prior to this project, organizations were not thinking about the benefits of collaborating." In time, the hospitals became more comfortable with sharing data and best practices, and the degree

of transparency increased. Eventually, the group members embraced the notion of helping each other improve to meet their mutual commitment to advancing safety in pediatrics.

Anderson asserts that transparency was instrumental and essential for improving pediatric care at CCH and within the OCHA member hospitals. “Transparency communicated to stakeholders within our hospital and within the collaborative that the first priority was taking care of children by providing high quality and safe care. Transparency also supplied the process and outcomes data that fueled a strong determination to improve.”

### **Postscript: Expanding Improvement Beyond Ohio**

Based on their track record with transparency and improvement, the now eight hospitals in OCHA were invited in 2011 to join 25 other pediatric hospitals from across the country to form the Children’s Hospitals’ Solutions for Patient Safety (SPS) network. By 2013, the group had expanded to include 78 hospitals in 33 states and the District of Columbia.

With an overarching goal of reducing or eliminating harm to children during care, SPS is guided by five tenets:

- Executive leadership is critical and must be supported through opportunities for skills development.
- The mission of improving outcomes for children informs the network hospitals’ actions; outcomes are achieved through a focus on quality improvement methods and reliability principles.
- Network hospitals commit to:
  - Refraining from competing on safety
  - Sharing lessons learned with others
  - Building a “culture of safety”

In 2014, the network hospitals committed to three shared goals by year’s end:

- 40% reduction in hospital-acquired conditions
- 20% reduction in readmissions
- 25% reduction in serious safety events

While active in the SPS, the eight OCHA member hospitals also continue to collaborate through the Ohio Children’s Hospitals’ Solutions for Patient Safety.



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## DISCLOSURE STATEMENT

The National Patient Safety Foundation, in accordance with our conflict of interest policy, has asked all members of the NPSF Lucian Leape Institute and all participants in the Roundtable on Transparency to disclose material facts and potential conflicts of interest associated with the roundtable discussions and the content of this report.

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