SHINING A LIGHT

Safer Health Care Through Transparency

The National Patient Safety Foundation's Lucian Leape Institute

Report of the Roundtable on Transparency

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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