



TAHOE FOREST HOSPITAL DISTRICT

2016-06-14 Board Quality Committee

Tuesday, June 14, 2016 at 12:00 p.m.

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2016-06-14 Board Quality Committee

6/14/16 Board Quality Committee

AGENDA

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6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

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6.2. Patient & Family Centered Care

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6.4. Healthcare Facilities Accreditation Program (HFAP) Survey
No related materials.

6.5. Board Quality Education

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QUALITY COMMITTEE AGENDA

Tuesday, June 14, 2016 at 12:00 p.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL

Greg Jellinek, M.D., Chair; Karen Sessler, M.D., Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE

This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 4/5/2016 ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Quality Committee Charter and Goals 2016 ATTACHMENT

The *Quality Committee Charter and Goals 2016* were approved by the Committee at the February 9, 2016 meeting. Informational for reference during the meeting if needed.

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Patient & Family Advisory Council Update ATTACHMENT

An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC).

6.3. BOD Quality & Service Excellence Dashboard ATTACHMENT

Discuss the quality and service excellence dashboard and the process for BOD review including content, quality metrics, benchmarks, and plans for improvement.

6.4. Healthcare Facilities Accreditation Program (HFAP) Survey

Provide an update on preparation for the unannounced triennial HFAP accreditation survey in the spring of 2017.

6.5. Board Quality Education ATTACHMENT

6.5.1. The Committee will review and discuss key learning points from the following articles:

6.5.1.1. BMJ Article *Medical Error—the third leading cause of death in the US* (May 3, 2016)

6.5.1.2. National Patient Safety Foundation (NPSF) Article *Shining a light: Safer healthcare through transparency* (2015)

6.5.1.3. CHA's *Governance Role in Quality and Performance Improvement* Webinar presentation (June 1, 2016)

6.5.2. Committee will review and discuss future topics for Board Quality education.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The date and time of the next committee meeting, Tuesday, August 16, 2016, will be proposed and/or confirmed.

9. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.



QUALITY COMMITTEE

DRAFT MINUTES

Tuesday, April 5, 2016 at 12:00 p.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA

1. CALL TO ORDER

Meeting was called to order at 12:02 p.m.

2. ROLL CALL

Board: Greg Jellinek, M.D., Chair; Karen Sessler, M.D., Board Member

Staff: Harry Weis, CEO; Judy Newland, CNO/COO; Jake Dorst, CIO; Janet Van Gelder, Director, Quality & Regulations; Carl Blumberg, Risk and Patient Safety Officer; Jean Steinberg, Director, Medical Staff Services; Jim Sturtevant, Director, Acute Services; John Rust, Director, Emergency Services; Trish Foley, Patient Advocate; Ted Owens, Executive Director; Paige Thomason, Marketing Director; Martina Rochefort, Clerk of the Board

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

No changes were made to the agenda.

4. INPUT – AUDIENCE

No public comment was received.

5. APPROVAL OF MINUTES OF: 2/9/2016

Director Jellinek moved approval of the Quality Committee minutes of February 9, 2016 with the following change to remove the second “not” from Item 6.5., third paragraph, last line.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Quality Committee Charter and Goals 2016

Charter and Goals were provided for reference only. No discussion was held.

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Patient & Family Advisory Council Update

Trish Foley provided an update on the activities of the Patient and Family Advisory Council (PFAC).

A section regarding process improvement activities has been added to the PFAC log.

PFAC received a suggestion in February for the ED to have headphones available for patients that have phones but do not have a way to listen and block out noise. ED has since ordered disposable headphones that will be made available to patients.

PFAC consists of 8 council members. Ms. Foley is still trying to recruit members. Generally, 3-5 members show up to the meetings.

Discussion was held regarding a former employee potentially sitting on Ethics Committee as Community Member. It was discussed that Ethics Committee members should have no work history with the District.

Ms. Foley indicated it was very valuable having Directors attend PFAC meetings to review their operations and obtain feedback from the Council.

6.3. 4th Quarter 2015 BOD Quality Dashboard

Janet Van Gelder, Director of Quality and Regulations reviewed the 4th Quarter 2015 Quality Dashboard.

The 4th Quarter 2015 BOD Quality Dashboard will be shared at the committee level going forward.

CMS has removed the Heart Failure Care, Pneumonia Care and SCIP Care measures in 2016 and added the Sepsis bundle metrics.

On the immunization measure, Jim Sturtevant had the nurses perform a self-audit as well as audit each other. He realized the best way to improve the measure was to correct it themselves. January's summary showed green on the report. February is also expected to be green. Immunization tracking was challenging in CPSI. For example, immunizations would not be recorded or a box that the patient refused the immunization would not be checked. Immunizations are not measured beyond March 31 each year.

The rating for Long Term Care is back up to 5 star.

Director Jellinek suggested sending out a press release for this information.

The Primary C-section Rate shown on the scorecard did not calculate correctly. It should show as 19.4%. Dr. Coll indicated the C-Section rate over the last year was 16%. The national goal is trying to get down from 32% to 24%.

Director Sessler inquired if the Quality Dashboard should be reviewed as an open session item at the Board Meetings. Ms. Van Gelder noted that every measure on the dashboard is publicly reported on the Hospital Compare web site except medication errors. Director Sessler also suggested the Dashboard should show how the District's goals are much more stringent against national goals. Ms. Van Gelder will add a column with the National benchmark.

Director Sessler felt the Quality Committee should discuss at its next meeting how the Dashboard will be show at BOD meeting in open session. Dr. Coll agreed.

6.4. HCAHPS Star Rating Report

Ms. Van Gelder sent a summary to Board regarding a recently released Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Star Rating Report. TFHD received an overall rating of 4 stars. The report release covers 4/1/13-3/31/15. TFHD received 5 stars on patient's willingness to recommend and communication from nurses.

Mr. Sturtevant introduced a new daily rounding form that is being used internally. Mr. Sturtevant began daily rounding with patients concurrent with Kerry Milligan and Missy Pursel (Women and Family). They have started to ask patients the exact questions on surveys so the hospital can have real time information. Consistent complaints have been received about wheels on carts and door shutting in Med Surg for patients in rooms 202 and 204.

Director Jellinek commented this is empowering patients to provide feedback on our processes. Mr. Sturtevant and his team also call all inpatients 48-72hrs after discharge to ask them how their care was and proactively reach out.

A Yacker Tracker device to monitor the level of noise was set up in ICU. The doors set it off red more than anything else. Mike Ruggiero is replacing the door's hardware.

Service Excellence Performance Improvement team meets monthly and proposes rounding based on priority index. This is a new initiative for other directors as well.

Ms. Van Gelder thanked Jim Sturtevant for all of his hard work on these initiatives.

Press Ganey will be on site at TFHD at the end of April for an annual meeting with our Account Executive.

Committee would like the daily rounding form to go to the Board meeting.

If the hospital can bring three of the measures back up to a score of 5, we will get the overall 5 star rating back.

Director Jellinek inquired how many hospitals had a 4-star rating. It was unknown exactly how many CEO suggested saving results if CMS does not post past data.

Discussion was held on the challenges of the current outsourced operator system. CIO is testing new voice system that will streamline the experience for callers.

6.5. Credentialing & Peer Review Process

Jean Steinberg reviewed the Credentialing Privileging and Peer Review Process presentation.

MEC looking at streamlining Med Staff Org Chart and will be reviewing over the next few months.

Credentialing was brought back in-house last month. Currently, there 8 applications in process.

Privileges are granted or renewed by the Board of Directors.

Board will see reports in the future with categories listed showing the depth of review by Med Staff.

MEC may choose to lower the number for hospital encounters from 20.

Director Jellinek inquired why credentialing was brought back in house. Ms. Steinberg indicated the credentialing process is cheaper and quicker than CVOs.

Committee requested the presentation be added to the portal for board education.

6.6. Accreditation Association for Hospitals and Health Systems

AAHHS asked if the District was interested in a complimentary survey. Quality is working with Judy Newland and staff to coordinate the complimentary survey. This will prepare the District for its HFAP survey in 2017. The timing of complimentary survey is still to be determined.

6.7. Patient Safety Report

Carl Blumberg, Risk and Patient Safety Officer, reviewed a report of National Quality Forum (NQF) Endorsed Set of 34 Safe Practice and report on process improvement activities within each category.

This report will be updated on a calendar year basis.

Mr. Blumberg highlighted items #1 - Patient Safety and Risk Management Plans, #7 - Disclosure, #8 - Care for the Caregiver. Mr. Blumberg indicated item #17 –Medication Reconciliation has been a challenge but should be resolved with a new EMR system.

Further discussion was held about item #7 – Disclosure. Dr. Coll shared a patient experience after disclosure was given regarding care. Patient was happy with care that followed and appreciated transparency.

6.8. Community Education

Item 6.8. was heard prior to Item 6.3. to accommodate presenter's schedule.

Ted Owens, Director of Community Development and Governance, and Paige Thomason, Director of Marketing and Communications discussed changes that were made to the website. Quality pages have been cleaned up and testimonials were added.

Marketing is working on another issue of the Tahoe Forest magazine. They would like to highlight the PFAC in the next issue as a feature story. The issue will be released in the summer.

Press Releases have boilerplate quality highlights. Surveys go out via press release.

TV is becoming another forum for communicating with the public. The District has already filmed two episodes of Mountain Health Today. They will air on channel 6 in Truckee and channel 18 at the lake. This will be a different way to share education topics to the public. The first two were shot with CEO and are currently in edit mode. Quality would be a great topic to have highlighted in the future. These will be able to be accessed via the TFHD website as well for 2 years. This will be part of education library the District is building so members of the public can access at any time.

Dr. Coll inquired if physicians who speak at large engagements should also be recorded for the library. Mr. Owens indicated if the District had permission and enough notice that could be possible.

Discussion was held regarding the marketing campaign at IVCH. The care concept for IVCH is in final revisions. This will also be a good feature story for the next magazine.

Director Sessler asked if this would be an opportunity to reach out Spanish speaking community by taping a segment in Spanish. Mr. Owens will reach out to the Family Resource Center. It may also be possible to add subtitles. Dr. Coll suggested including Spanish speaking doctors and nurses.

6.9. Board Quality Education

Barton is hosting a Rural Healthcare Conference. Mr Weis and three physicians from the Education Committee will be attending.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

No discussion was held.

8. NEXT MEETING DATE

The next committee meeting is confirmed for Tuesday, June 14, 2016 at 12:00 p.m.

9. ADJOURN

Meeting adjourned at 1:41 p.m.

DRAFT

Board Quality Committee Goals 2016

1. Provide appropriate resources to assist the Patient & Family Advisory Council (PFAC) improvement initiatives.
2. Monitor quality and patient safety metrics and support processes, with a focus on outliers, to achieve top decile performance.
3. Provide direction on the Quality and Service elements of the Health System strategic plan and the Quality Assurance/Performance Improvement (QA/PI) Plan.
4. Review quality and service metrics with the community through multi-media venues (i.e., web site, public speaking, social media, quarterly magazine, newspaper articles, etc.).
5. Utilize Just Culture principles when notified of sentinel/adverse events, including the disclosure of medical errors, and when patients share their experience.
6. Promote a culture of openness and transparency related to quality of care and patient safety.
7. Oversee the integrity and reliability of the credentialing and peer review process.
 - a. Utilizing best practice protocols where applicable and following quality and safety standards, i.e., demonstrating training and use of SBAR and handoff communication.
8. Request that the Quality Department evaluate Patient Satisfaction survey vendors and determine if a change in vendor is warranted.
9. Prepare for Critical Access Hospital's participation in CMS Hospital Value-Based Purchasing program through the monitoring of Clinical Process of Care, Patient Experience, and Outcome measures.

Quality Committee Charter

Tahoe Forest Hospital District is committed to performance excellence, to delivering the highest quality care and service, and to exceeding the expectations of our patients, physicians, employees, and community. This committee will provide leadership, oversight, and accountability for organization wide quality improvement processes and programs. We will regularly assess the needs of our stakeholders, evaluate proposed quality initiatives, openly debate options, and assure the production of an organization wide strategic plan for quality. We will set expectations, facilitate education, and support the monitoring of the quality of care, service excellence, risk reduction, safety enhancement, performance improvement, and healthcare outcomes. Because of our efforts Tahoe Forest Hospital District will be the best place to receive care, the best place to work, the best place to practice medicine, and a recognized asset to all in our community.

Approved January 22, 2014

2016 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
1st Quarter 2016				
1/19/16	Orientation/Recruitment Signage for Health Alerts Visitor Policy	PFAC Laurel Homer Nursing Leadership	Discussed the option for council members to become hospital volunteers vs. a revised orientation for members who wish to volunteer only for the council. The option was discussed for council members to participate in recruitment of new members if available and interested. Signage was reviewed for patient care areas to include a 'Reminder' message of keeping our patients healthy vs. a 'STOP' message. Visitor Policy was reviewed with the goal to be more Patient and Family Centered by identifying 'visitors' as partners and/or guests and recognizing family and guest presence as essential to patient care, quality, and safety (<i>Better Together</i> concept through the Institute of Patient and Family Centered Care). Ideas were explored about the next steps for the PFAC to include inviting members to attend various meetings at the hospital (i.e. Board Quality and Safety Committee) and scheduling Department Directors to attend the PFAC meetings to gain input on any areas for process improvement.	Pending signage for Infection Control Pending Visitor Policy update

2016 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
2/16/16	ED Review/Feedback Lab Review/Feedback PFAC Charter Committee Representatives	John/Jan Vern/Sharon PFAC PFAC	Guest speakers John and Jan, from the Tahoe Forest and Incline Village Emergency Departments and Sharon and Vern, from Tahoe Forest Laboratory Services provided information about their departments and obtained feedback from PFAC members. John and Jan are looking into headphones for the ED to help with noise reduction. Both ED locations are addressing wait times and keeping patients informed of delays. Also, trying to decrease the amount of discharge information or highlighting the important aspects of instructions provided to patients. Sharon and Vern provided information on laboratory scheduling and we reviewed the online process which was patient-user friendly! The front desk now has another staff member assisting with releasing lab orders so the process can move more quickly and hope to minimize wait times. We reviewed the PFAC Charter to encourage interested members who wish to either be Co-Chair or Secretary to participate in these roles. Also, inquired if anyone was interested in attending an upcoming Women and Family meeting, and Inpatient Unit meetings to share their experience with the Whiteboard process. Times will also be provided for other Committee Meetings (Ethics, Board Quality, and Safety) for interested members who would like to participate.	Headphones in ED to offer to patients for noise control Pending attendance from PFAC members on Committees

2016 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
3/15/2016	Foundation Gift Items DI//Patient Registration (Review/Feedback) Dietary Review/Feedback Photography Signage	Martha Pete/Tory Coni/Tammy Mike Ruggiero	Guest speakers; Martha, Pete, Tory, Coni, and Tammy. Martha reviewed the Grateful Patient Program and inquired ideas on a small ‘gift’ item that could be provided to inpatients with Foundation information. Suggestions were chap stick, lotion, eye masks, earphones, robes and gowns. Pete and Tory relayed information on the services provided from the Diagnostic Imaging and Patient Registration Departments. Information was provided about pricing, time for appointments, radiation doses, and authorizations that can take time to obtain. There was discussion about authorizations for observation patients and whether this was needed depending on insurance benefits. Coni presented information on the Dietary Department and their goals of increasing the amount of homemade products, improving top box scores from patient surveys, and changing scheduled mealtimes to more of a ‘room service’ environment. Both Coni and Tammy were available to answer questions. Signage for ‘no photography’ was reviewed with suggestions to have patient and family friendly wording to ‘kindly refrain from photography to protect patient, family and staff privacy.....’ with perhaps a fun picture of a person with too many cameras vs. a ‘NO photography’ sign. Reminder to PFAC members about council representation on various Committees if interested.	Pending electronic notification sent to Financial Counselor of observation vs. inpatient status change to start any required authorizations asap. Pending signage for photography guidelines

2016 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
4/19/2016	Year Celebration of PFAC! Extended Care Center Hospice/Home Health Wellness Neighborhood	ALL Sarah Jane Stull Max Hambrick Maria Martin	Celebration of the one year anniversary of the council and acknowledgments to the members and team for their contribution and support! Guest speakers Sarah Jane, Max, and Maria. Information was provided on Hospice/Home Health Services, the Extended Care Center (ECC), and the Community Health and Wellness Program. We spent time discussing noise reduction in the ECC, timely initiation to care, and 7 day/week coverage for Hospice/Home Health Services. Suggestions for noise reduction included awareness of loud doors and perhaps identifying an app. on the iPad for white noise or soothing noise. Also, the group explored how to provide more outreach/education to the community regarding the Community Health and Wellness Program. Suggestions included Facebook, TFHD website, and advertising with local community groups. Participants acknowledged how all the services are addressing community needs and how lucky we are to live in an area where we have these services!	
2nd Quarter 2016				

2016 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
5/17/2016	Cancer Center Environmental Services Respiratory Therapy	Cathey Bervid Jason Grosdidier Jason Grosdidier	<p>Guest speakers Cathey and Jason. Cathey provided an overview of the Cancer Center services for patients and the community, and discussed areas they are working on for process improvements. This included developing a newsletter for patients, increasing the frequency of distress screening for patients, scheduling patients for initial appointments sooner, and reviewing treatment costs (co pays, deductibles, out of pocket expenses, etc.) with patients. Jason provided information on Environmental Services and Respiratory Therapy. Environmental Services are provided 24 hours/day at the Cancer Center, Main Hospital, and at Incline Village Community Hospital. They are constantly evaluating the best products and equipment to use, to ensure effectiveness, cleanliness, and safety for patients and staff. Respiratory Therapy is provided for all hospital areas treating patients. The hope is to expand services to include more extensive pulmonary function testing and also to bring the sleep program provided at IVCH to the Tahoe Forest Hospital Truckee location. Participants acknowledged how fortunate we are to have these services in our community, and feedback was also provided that hospital staff seems to enjoy their jobs and provide a great service ☺ Also, a suggestion was brought up about the possibility of having a ‘starter pack’ for medications when patients are discharged from the hospital to bridge the time until patients or family members are able to obtain prescriptions from a pharmacy. The idea would be for perhaps a two day supply if this would be possible. Reminder was given for anyone interested in being a council representative on a Committee (Ethics, Safety, and Board Quality) to contact Trish or Janet.</p>	<p>Hilary was contacted and she reports TFHD Pharmacy is already looking into a discharge medication to bedside program with our Retail Pharmacy.</p>

2016 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
3rd Quarter 2016				
4th Quarter 2016				

TFHS BOD Quality Scorecard

- Goal Met or Exceeded
- Within 10% Negative Variance of Goal
- Greater than 10% Negative Variance

- TFHS Goal*
- Benchmark*
- Quarterly Performance

* Unless Noted Otherwise

Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
Heart Attack Care (0 pt)		96.7%	<p>Goal: To meet/exceed the national average for recommended evidence-based care provided for heart attack patients. This number represents a roll-up of 4 AMI measures. National Average = 88.5% (T, E,P)</p> <p>Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.</p>	
TFH Immunizations		100.0%	<p>Goal: To vaccinate 100% of all appropriate consenting inpatients for pneumonia and influenza. This number is a roll up of both IMM measures (T, E, Ef, Eq, P) National Average Flu = 93% & Pneumo = 88.2%</p> <p>Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.</p>	
TFH VTE Care (24 pts)		100.0%	<p>Goal: To achieve 100% of all six process measures associated with VTE Care. (T, E, Ef, Eq, P) National Average = Unknown</p> <p>Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.</p>	
TFH Stroke Care (0 pts)		100.0%	<p>Goal: To achieve 100% of all five process measures associated with Stroke Care. (T, E, Ef, Eq, P) National Average = 96.4%</p> <p>Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.</p>	
TFH Hospital Acquired Surgical Infections		1.0%	<p>Goal: SSI 0% or a procedure-specific Standardized Infection Ratio (SIR) <1 when # of surgeries allows for SIR calculation. (replaces national average)</p> <p>Q1: PI: Continue to review trends at the Quarterly Medical Staff meeting.</p>	
TFH Hospital Acquired non-Surgical Infections		0.0%	<p>Goal: device-related HAI and AIM 0% and SIR <1; SIR is calculated when predicted # of infections is greater or = to 1. represents a roll-up of device-related infections: CLABSI, VAE, CAUTI, and MRSA infections.</p> <p>Q1: PI: Continue to review trends at the Quarterly Medical Staff, Nursing Staff & Infection Control Committee meeting.</p>	

TFHS BOD Quality Scorecard

- Goal Met or Exceeded
- Within 10% Negative Variance of Goal
- Greater than 10% Negative Variance

- TFHS Goal*
- Benchmark*
- Quarterly Performance

* Unless Noted Otherwise

Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
IVCH Hospital Acquired Surgical Infections		1.0%	Goal: SSI 0% or a procedure-specific Standardized Infection Ratio (SIR) <1 when # of surgeries allows for SIR calculation. Q1: PI: Continue to review trends and areas of concern at the Quarterly Medical Staff, Nursing Staff & Infection Control Committee meeting.	
SNF 5-Star Quality Rating		5	Goal: To maintain an overall 5-Star rating for the CMS Nursing Home Criteria. This includes Health Inspection deficiencies, Nursing Home Staffing Measures (4), Quality Measures (19), and Fire Inspection deficiencies (S, T, E, E, E, P) Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Pain		64.0%	Goal: P4P measurement, managing pain and treating symptoms, how often patients had less pain when moving around. Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Bathing		64.0%	Goal: P4P measurement, managing daily activities, how often patients go better at bathing. Q1: PI: Continue to review at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Ambulation/ Locomotion		44.0%	Goal: P4P measure, managing daily activities, how often patients got better at walking or moving around. Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Surgical Wounds		80.0%	Goal: P4P measure, treating wounds and preventing pressure sores, how often patients wounds improved or healed after an operation. (S, T, E, P) Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	

TFHS BOD Quality Scorecard



- Goal Met or Exceeded
- Within 10% Negative Variance of Goal
- Greater than 10% Negative Variance



* Unless Noted Otherwise

- TFHS Goal*
- Benchmark*
- Quarterly Performance

Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
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S-safe, T-timely, E-effective, EF-efficient, EQ-equitable, P-patient centered

TFHS BOD Service Excellence Scorecard



- Goal Met or Exceeded
- Within 10% Negative Variance of Goal
- Greater than 10% Negative Variance



TFHS Goal*



Benchmark*



Quarterly Performance

* Unless Noted Otherwise

Quality Measures	Q1-2016	Goal	Goal Description and Quarterly Events	Quarterly Trend
HCAHPS Top Box Score, reported by Press Ganey, "Recommend this Hospital"		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for inpatient satisfaction. National Score = 71% (S, T, EQ, P) Q1: PI: Director/Manager daily patient rounds. Patient follow up phone calls after discharge. Quiet environment initiative using visual and verbal cues.	
HCAHPS Top Box Score, reported by Press Ganey, "Rate this Hospital 9 or 10"		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for inpatient satisfaction. National Score = 72% (S, T, EQ, P) Q1: PI: Director/Manager daily patient rounds. Patient follow up phone calls after discharge. Quiet environment initiative using visual and verbal cues.	
Home Health HHCAHPS "Rate this Agency 9 or 10" Top Box Score		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for Home Health Patient satisfaction. HHCAHPS national average is 84% (S, T, EQ, P) Q1: PI: Results reviewed at staff meeting with a focus on MDS metric education & scripting of key areas noted on survey responses. Director patient rounding. Follow up phone calls.	
Home Health HHCAHPS "Recommend this Agency" Top Box Score		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for Home Health Patient satisfaction. HHCAHPS national average is 79% (S, T, EQ, P) Q1: PI: Results reviewed at staff meeting with a focus on MDS metric education & scripting of key areas noted on survey responses. Director patient rounding. Follow up phone calls.	

S-safe, T-timely, E-effective, EF-efficient, EQ-equitable, P-patient centered

ANALYSIS



Medical error—the third leading cause of death in the US

Medical error is not included on death certificates or in rankings of cause of death. **Martin Makary** and **Michael Daniel** assess its contribution to mortality and call for better reporting

Martin A Makary *professor*, Michael Daniel *research fellow*

Department of Surgery, Johns Hopkins University School of Medicine, Baltimore, MD 21287, USA

The annual list of the most common causes of death in the United States, compiled by the Centers for Disease Control and Prevention (CDC), informs public awareness and national research priorities each year. The list is created using death certificates filled out by physicians, funeral directors, medical examiners, and coroners. However, a major limitation of the death certificate is that it relies on assigning an International Classification of Disease (ICD) code to the cause of death.¹ As a result, causes of death not associated with an ICD code, such as human and system factors, are not captured. The science of safety has matured to describe how communication breakdowns, diagnostic errors, poor judgment, and inadequate skill can directly result in patient harm and death. We analyzed the scientific literature on medical error to identify its contribution to US deaths in relation to causes listed by the CDC.²

Death from medical care itself

Medical error has been defined as an unintended act (either of omission or commission) or one that does not achieve its intended outcome,³ the failure of a planned action to be completed as intended (an error of execution), the use of a wrong plan to achieve an aim (an error of planning),⁴ or a deviation from the process of care that may or may not cause harm to the patient.⁵ Patient harm from medical error can occur at the individual or system level. The taxonomy of errors is expanding to better categorize preventable factors and events.⁶ We focus on preventable lethal events to highlight the scale of potential for improvement.

The role of error can be complex. While many errors are non-consequential, an error can end the life of someone with a long life expectancy or accelerate an imminent death. The case in the box shows how error can contribute to death. Moving away from a requirement that only reasons for death with an ICD code can be used on death certificates could better inform healthcare research and awareness priorities.

How big is the problem?

The most commonly cited estimate of annual deaths from medical error in the US—a 1999 Institute of Medicine (IOM) report⁷—is limited and outdated. The report describes an incidence of 44 000–98 000 deaths annually.⁷ This conclusion was not based on primary research conducted by the institute but on the 1984 Harvard Medical Practice Study and the 1992 Utah and Colorado Study.^{8,9} But as early as 1993, Leape, a chief investigator in the 1984 Harvard study, published an article arguing that the study's estimate was too low, contending that 78% rather than 51% of the 180 000 iatrogenic deaths were preventable (some argue that all iatrogenic deaths are preventable).¹⁰ This higher incidence (about 140 400 deaths due to error) has been supported by subsequent studies which suggest that the 1999 IOM report underestimates the magnitude of the problem. A 2004 report of inpatient deaths associated with the Agency for Healthcare Quality and Research Patient Safety Indicators in the Medicare population estimated that 575 000 deaths were caused by medical error between 2000 and 2002, which is about 195 000 deaths a year (table 1↓).¹¹ Similarly, the US Department of Health and Human Services Office of the Inspector General examining the health records of hospital inpatients in 2008, reported 180 000 deaths due to medical error a year among Medicare beneficiaries alone.¹² Using similar methods, Classen et al described a rate of 1.13%.¹³ If this rate is applied to all registered US hospital admissions in 2013¹⁵ it translates to over 400 000 deaths a year, more than four times the IOM estimate.

Similarly, Landrigan et al reported that 0.6% of hospital admissions in a group of North Carolina hospitals over six years (2002–07) resulted in lethal adverse events and conservatively estimated that 63% were due to medical errors.¹⁴ Extrapolated nationally, this would translate into 134 581 inpatient deaths a year from poor inpatient care. Of note, none of the studies captured deaths outside inpatient care—those resulting from errors in care at home or in nursing homes and in outpatient care such as ambulatory surgery centers.

Case history: role of medical error in patient death

A young woman recovered well after a successful transplant operation. However, she was readmitted for non-specific complaints that were evaluated with extensive tests, some of which were unnecessary, including a pericardiocentesis. She was discharged but came back to the hospital days later with intra-abdominal hemorrhage and cardiopulmonary arrest. An autopsy revealed that the needle inserted during the pericardiocentesis grazed the liver causing a pseudoaneurysm that resulted in subsequent rupture and death. The death certificate listed the cause of death as cardiovascular.

A literature review by James estimated preventable adverse events using a weighted analysis and described an incidence range of 210 000-400 000 deaths a year associated with medical errors among hospital patients.¹⁶ We calculated a mean rate of death from medical error of 251 454 a year using the studies reported since the 1999 IOM report and extrapolating to the total number of US hospital admissions in 2013. We believe this understates the true incidence of death due to medical error because the studies cited rely on errors extractable in documented health records and include only inpatient deaths. Although the assumptions made in extrapolating study data to the broader US population may limit the accuracy of our figure, the absence of national data highlights the need for systematic measurement of the problem. Comparing our estimate to CDC rankings suggests that medical error is the third most common cause of death in the US (fig 1).²

Better data

Human error is inevitable. Although we cannot eliminate human error, we can better measure the problem to design safer systems mitigating its frequency, visibility, and consequences. Strategies to reduce death from medical care should include three steps: making errors more visible when they occur so their effects can be intercepted; having remedies at hand to rescue patients¹⁷; and making errors less frequent by following principles that take human limitations into account (fig 2). This multitier approach necessitates guidance from reliable data.

Currently, deaths caused by errors are unmeasured and discussions about prevention occur in limited and confidential forums, such as a hospital's internal root cause analysis committee or a department's morbidity and mortality conference. These forums review only a fraction of detected adverse events and the lessons learnt are not disseminated beyond the institution or department.

There are several possible strategies to estimate accurate national statistics for death due to medical error. Instead of simply requiring cause of death, death certificates could contain an extra field asking whether a preventable complication stemming from the patient's medical care contributed to the death. An early experience asking physicians to comment on the potential preventability of inpatient deaths immediately after they occurred resulted in an 89% response rate.¹⁸ Another strategy would be for hospitals to carry out a rapid and efficient independent investigation into deaths to determine the potential contribution of error. A root cause analysis approach would enable local learning while using medicolegal protections to maintain anonymity. Standardized data collection and reporting processes are needed to build up an accurate national picture of the problem. Measuring the consequences of medical care on patient outcomes is an important prerequisite to creating a culture of learning from our mistakes, thereby advancing the science of safety and moving us closer towards the Institute of Medicine's goal of creating learning health systems.¹⁹

Health priorities

We have estimated that medical error is the third biggest cause of death in the US and therefore requires greater attention. Medical error leading to patient death is under-recognized in many other countries, including the UK and Canada.^{20 21} According to WHO, 117 countries code their mortality statistics using the ICD system as the primary indicator of health status.²² The ICD-10 coding system has limited ability to capture most types of medical error. At best, there are only a few codes where the role of error can be inferred, such as the code for anticoagulation causing adverse effects and the code for overdose events. When a medical error results in death, both the physiological cause of the death and the related problem with delivery of care should be captured.

To achieve more reliable healthcare systems, the science of improving safety should benefit from sharing data nationally and internationally, in the same way as clinicians share research and innovation about coronary artery disease, melanoma, and influenza. Sound scientific methods, beginning with an assessment of the problem, are critical to approaching any health threat to patients. The problem of medical error should not be exempt from this scientific approach. More appropriate recognition of the role of medical error in patient death could heighten awareness and guide both collaborations and capital investments in research and prevention.

Contributors and sources: MM is the developer of the operating room checklist, the precursor to the WHO surgery checklist. He is a surgical oncologist at Johns Hopkins and author of *Unaccountable*, a book about transparency in healthcare. MD is the Rodda patient safety research fellow at Johns Hopkins and is focused on health services research. This article arose from discussions about the paucity of funding available to support quality and safety research relative to other causes of death. Competing interests: We have read and understood BMJ policy on declaration of interests and declare that we have no competing interests. Provenance and peer review: Not commissioned; externally peer reviewed.

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Summary points

Death certificates in the US, used to compile national statistics, have no facility for acknowledging medical error

If medical error was a disease, it would rank as the third leading cause of death in the US

The system for measuring national vital statistics should be revised to facilitate better understanding of deaths due to medical care

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Table

Table 1 | Studies on US death rates from medical error since the 1999 IOM report and point estimate from pooled results

Study	Dates covered	Source of information	Patient admissions	Adverse event rate (%)	Lethal adverse event rate (%)	% of events deemed preventable	No of deaths due to preventable adverse event	% of admissions with a preventable lethal adverse event	Extrapolation to 2013 US admissions†
Health Grades ¹¹	2000-02	Medicare patients	37 000 000	3.1	0.7*	NR	389 576	0.71	251 454
Office of Inspector General ¹²	2008	Medicare patients	838	13.5	1.4	44	12	0.62	219 579
Classen et al ¹³	2004	3 tertiary care hospitals	795	33.2	1.1	100	9	1.13	400 201
Landrigan et al ¹⁴	2002-07	10 hospitals in North Carolina	2341	18.1	0.6	63	14	0.38	134 581
Point estimate from all data	2000-08	—	—	—	—	—	—	0.71	251 454‡

NR=Not reported.

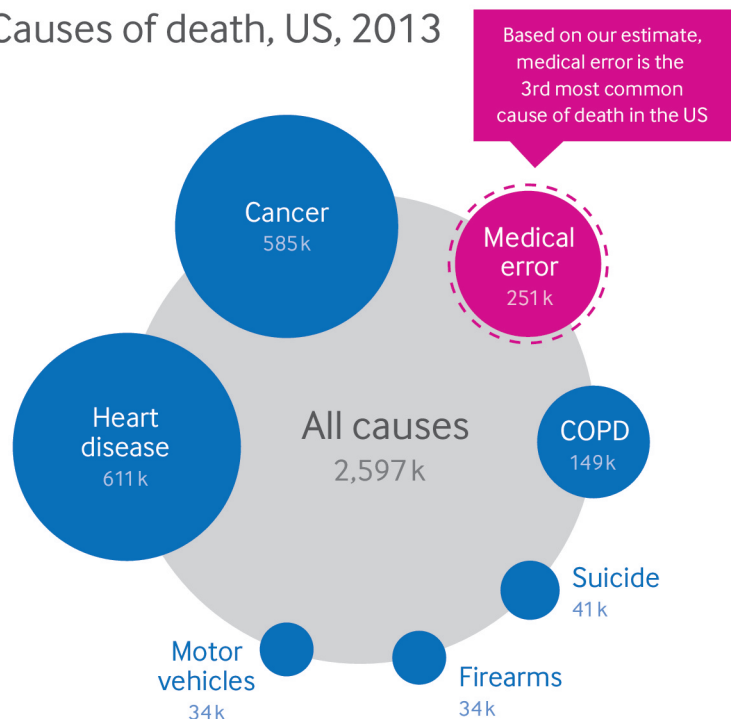
*All were considered preventable.

†Total number of US hospital admissions in 2013 was 35 416 020.¹⁰

‡Total number of people who died from a preventable lethal adverse event calculated as a point estimate of the death rate among hospitalized patients reported in the literature extrapolated to the reported number of patients hospitalized in 2013.

Figures

Causes of death, US, 2013



However, we're not even counting this - medical error is not recorded on US death certificates

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Data source:
http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

Fig 1 Most common causes of death in the United States, 2013²

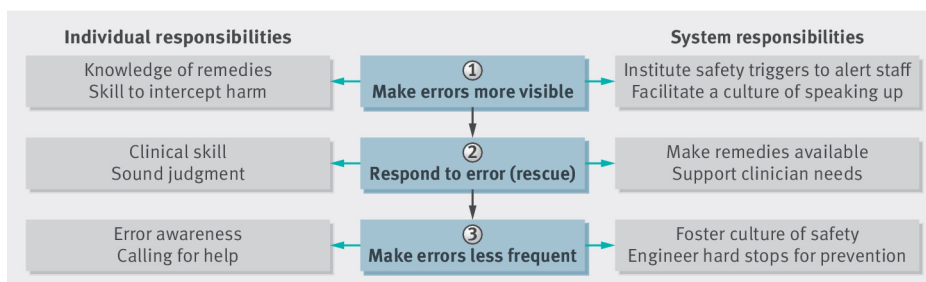


Fig 2 Model for reducing patient harm from individual and system errors in healthcare



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).

The National Patient Safety Foundation's Lucian Leape Institute gratefully acknowledges the following organizations for their generous support of the production and dissemination of *Shining a Light: Safer Health Care Through Transparency* and their commitment to transparency as an essential element in the delivery of safe care: Mallinckrodt Pharmaceuticals; MagMutual Patient Safety Institute; Cincinnati Children's; Duke Medicine; Edward P. Lawrence Center for Quality & Safety at Massachusetts General Hospital; Johns Hopkins Medicine; The Leapfrog Group; University of Michigan Health System; Virginia Mason Health System.

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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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The National Patient Safety Foundation's Lucian Leape Institute values your response to the report
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.

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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.

*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.¹ 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.²⁻³

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,⁴ and rates of early elective cesarean sections plummeted after implementation of a strategy of transparency and payment reform.⁵ 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.⁶⁻⁷ 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.⁸

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.⁹ 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.¹⁰ 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.¹¹ Recent studies have shown little progress in reducing the toll from medical errors.^{12–15} 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 1999.¹⁶

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.¹⁷ 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.”¹⁸ 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.^{19–20} 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.^{4,9–10,21–22} 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.²¹ 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.²³

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.²²

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.^{24–25} 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.²⁶⁻²⁷ 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.²² (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).

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.²⁸ 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.²⁹⁻³⁰ 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.³¹ 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.^{32–33}

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.³⁴

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.³⁵

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.³⁶ 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.³⁷ 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.³⁸

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.³⁹

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.^{6,40} 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)⁴¹
- 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*.⁴²)

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.

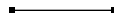
We call on health system leaders and clinicians to:

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,⁴³ 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.⁹

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.”⁴⁴ 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). 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.⁴⁵ 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.⁴⁵ 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 2008.⁴⁶ 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%.⁴⁷ 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.⁴⁸ 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.^{49–50}

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.⁵¹

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.⁵²

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

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Leah Binder
Richard Boothman
Lynne Chafetz
Gary Kaplan
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Welcome

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CHA Staff



Peggy Broussard Wheeler serves as CHA's vice president of Rural Health Care & Governance. She is responsible for advocating on behalf of small and rural hospitals at the state and national levels. Peggy also staffs CHA's Governance Forum Advisory Board, which promotes opportunities for hospital and health system trustee involvement in policy formulation, and political and legislative activities.



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Governance: Driver of Health Care Quality and Patient Safety

Julianne Morath, RN, MS, CPPS
CEO/President
Hospital Quality Institute

Governance: Driver of Health Care Quality and Patient Safety



Agenda Overview

- Role of governing boards
- Quality as a system
- Questions boards should be asking
- Quality accountability
- Performance measures
- Where to start



Board Performance is in the Headlines

Trustee

Home » How to Create a Better Board-CEO Relationship

How to Create a Better Board-CEO Relationship

3:47

Medical Errors Are No. 3 Cause Of U.S. Deaths, Researchers Say

May 3, 2016 - 6:31 PM ET

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QUALITY IS THE CENTER OF PATIENT CARE

Building healthy communities is a team sport. Hospitals and health systems must involve patients, their families, local communities and the nation to improve individual and community health. What characterizes the very best in health care? Quality - providing the safest, highest quality care in all settings.

The AHA/HRET Hospital Engagement Network (HEN) has worked with several hospitals in the Los Angeles area on areas of focus including reducing early elective deliveries, health care-acquired infections and reducing costs for patients.

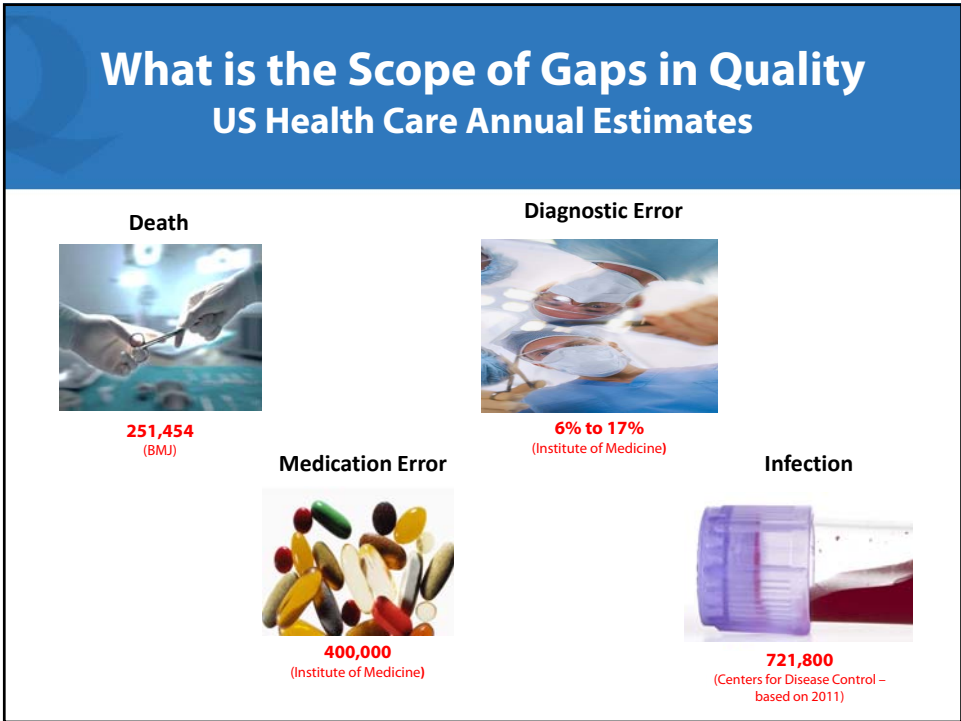
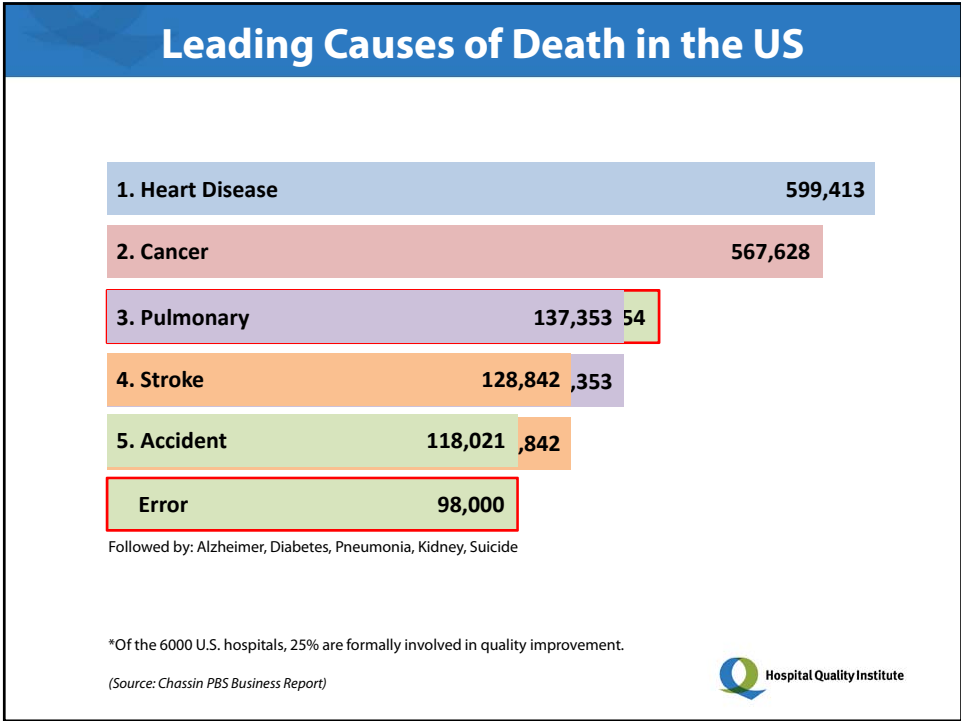
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State board lapses in infection control

Hospital Quality Institute



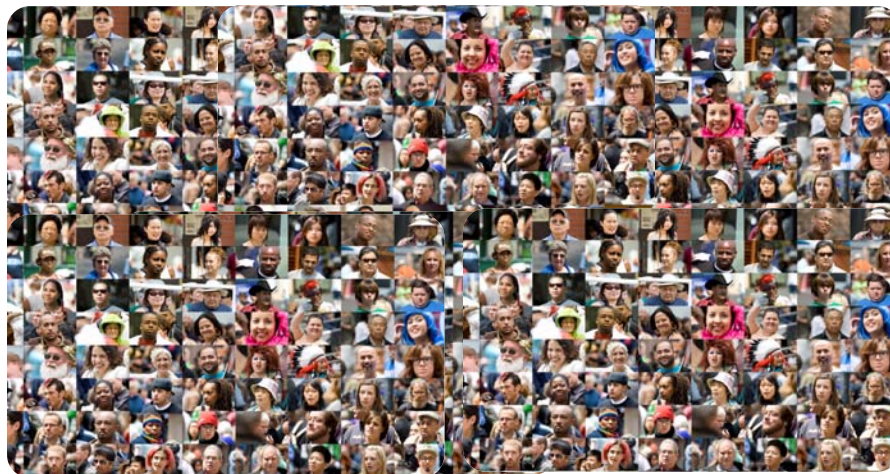
Questions for Leaders

1. Is this a safe place to give and receive care?
2. Does our culture encourage employees to tell the truth?
3. How do you know?
4. How do you find out?
5. Could this happen here?



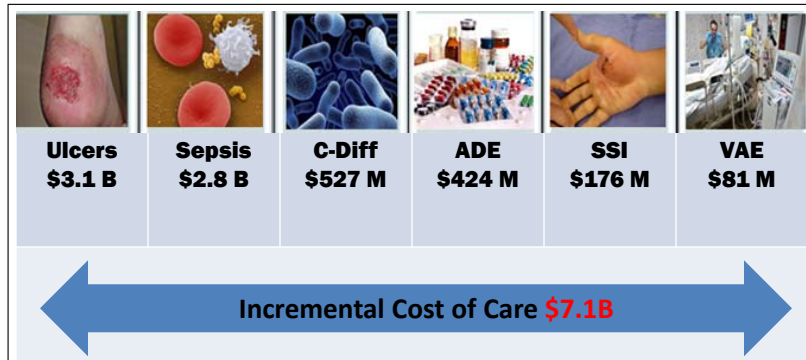
Board Responsibility of System Oversight

Depicted is the number of readmissions each day in California
(786 per day – 33 per hour)



Manage error, prevent failure, create safety and produce effective outcomes and optimal experiences.

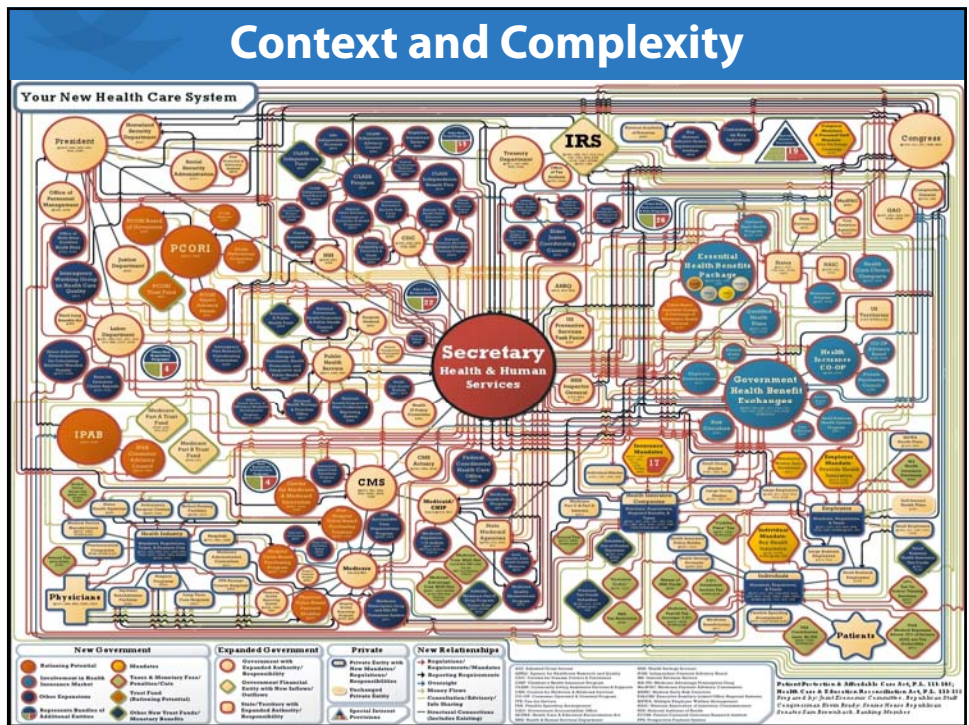
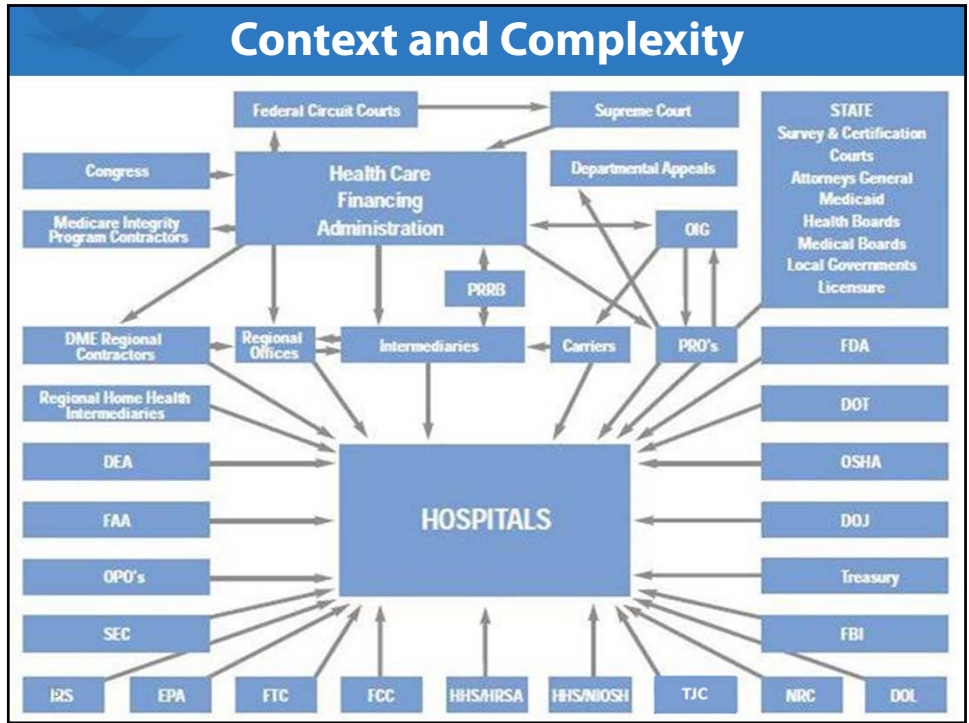
Top 6 Mostly Costly Hospital-Acquired Events in California



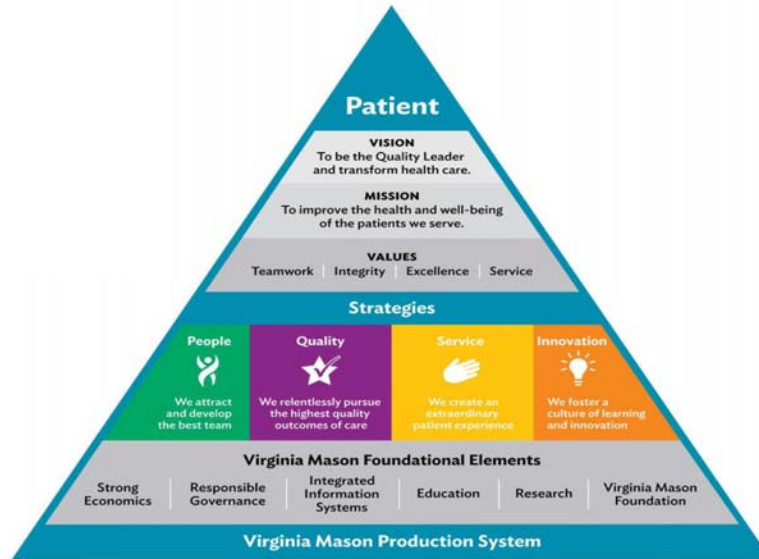
Incentives and Penalties Points to Remember About Quality-Based Payment Reform Programs

- Payment levels are at stake
- Historical data will continue to drive these programs
- Program targets move with national performance, so hospitals need to keep pace with the pack
- There is overlap with other quality-based payment reform programs (double jeopardy)





Create Alignment from Board Rooms to Frontlines



*Source: Virginia Mason Medical Center



HQI Board Compact

Organization's Responsibility

Promote Excellence

- Facilitate the recruitment and retention of superior board members
- Provide a process for regular evaluation and feedback of effectiveness
- Provide a thorough orientation process for new board members
- Support excellence with adequate resources

Listen and Communicate

- Share information regarding strategic intent, organizational priorities and business decisions
- Offer opportunities for constructive dialogue
- Report regularly on implementation of Blueprint and achievement of specific board objectives/directives
- Disclose to, and inform board on, risks and opportunities facing the organization
- Provide materials necessary for informed decision making sufficiently in advance of board meetings

Inform

- Provide information and tools necessary to keep members informed and current on quality and safety issues, and trends
- Educate board members about HQI, its structures and its guiding documents

Lead

- Manage and lead HQI with integrity and accountability
- Create strategies and goals
- Continuously measure and improve performance
- Identify, address and resolve conflict
- Ensure respect and psychological safety

Board Members' Responsibilities

HQI Programs

- Know vision and mission goals
- Be familiar with content of strategic Blueprint
- Keep informed on developments
- Understand statewide performance and gaps in state and nation related to quality and patient safety trends, challenges and opportunities

Focus on the Future

- Spend one-half of every meeting focused on the future
- Consistently maintain a current work plan

Listen and Communicate

- Actively participate in board discussions
- Participate in educational opportunities, and request information and resources needed to provide responsible oversight
- Provide and accept feedback
- Be an emissary and advocate for HQI in the state and regions
- Cascade communication

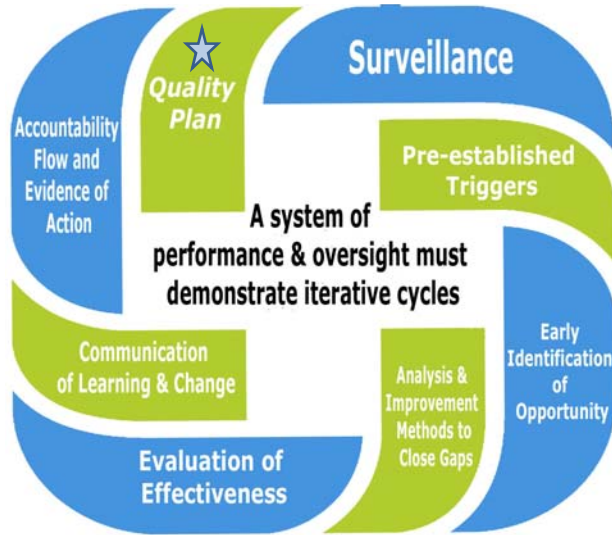
Take Ownership

- Assure vision and mission
- Attend meetings
- Ask timely and substantive questions at meetings
- Prepare for, participate in and support group decisions
- Understand and participate in approving annual budget
- Serve on committees or task forces as requested
- Require cooperation and collaboration, and make model the same

Promote Effective Changes

- Foster innovation and continuous improvement
- Pursue organizational change
- Model quality principles

Quality as a System

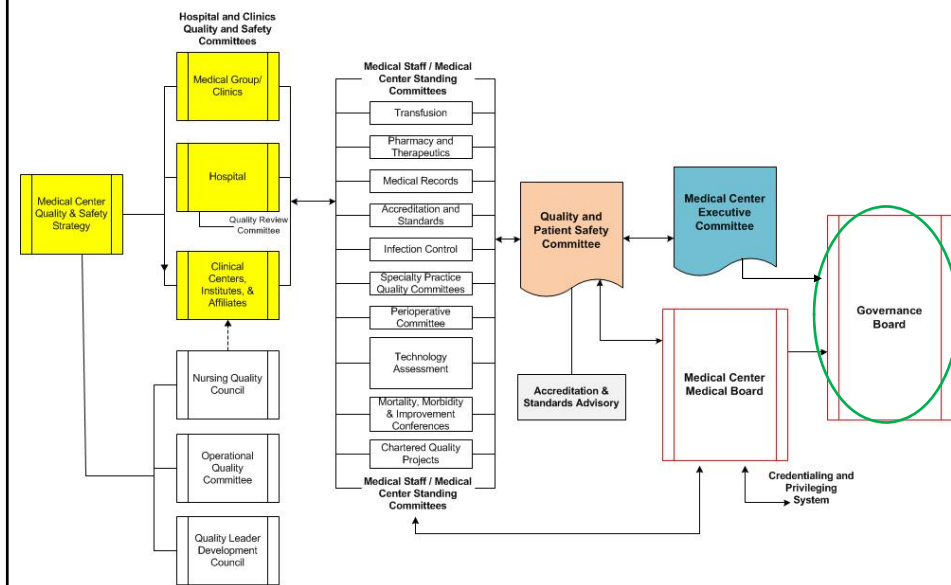


Escalation of Concern When Complaint or Failure is Evaluated:

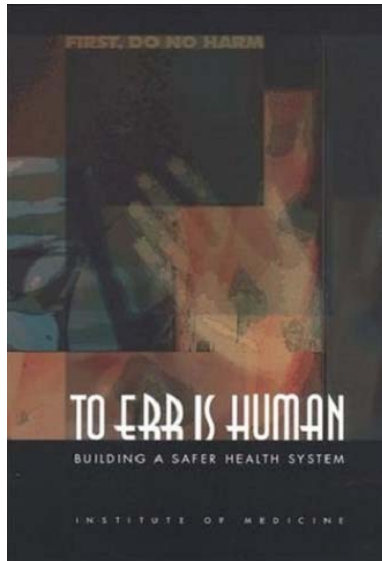
- Is this an ISOLATED Event?
- Is there a PATTERN of failure(s) in this area?
- Are there organizational SYSTEMIC ISSUE(s) related to quality performance and oversight?



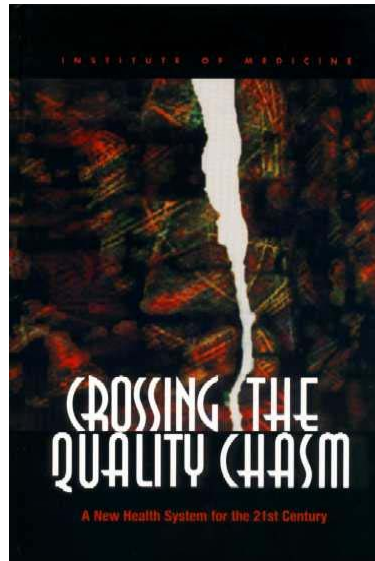
Example Quality & Safety Accountability & Reporting Flows



Courtesy of Hospital Quality Institute, www.hqiinstitute.org



SYSTEM



AIMS

Crossing the Quality Chasm

6 AIMS

- S** safe
- T** timely
- E** effective
- E** efficient
- P** patient-centered (person-centered)
- E** equitable

Questions You Should Ask: Connecting the Dots

1. Is there a systemic view, (e.g., planning process, strategy, design, drivers and measures)?
2. Are there measures that answer whether or not strategy is advancing, (i.e., is care getting better, or worse)?
3. How were the measures selected?
4. Why are the measures important to our hospital, patients, workforce and community?



Questions You Should Ask

5. Is there a coordinated process?
6. Can all staff leaders answer the following questions?
 - How does “this” compare to past?
 - How does “this” compare to best-of-class?
 - What are we doing to improve and close the performance gap?
 - What can we predict from what we know?
 - What might be unintended consequences of our improvement efforts?
7. How do we engage frontline caregivers, physicians, and patients and families?



Measurement



Set goals and monitor progress



Key Performance Indicators Pennsylvania Hospital - 1754

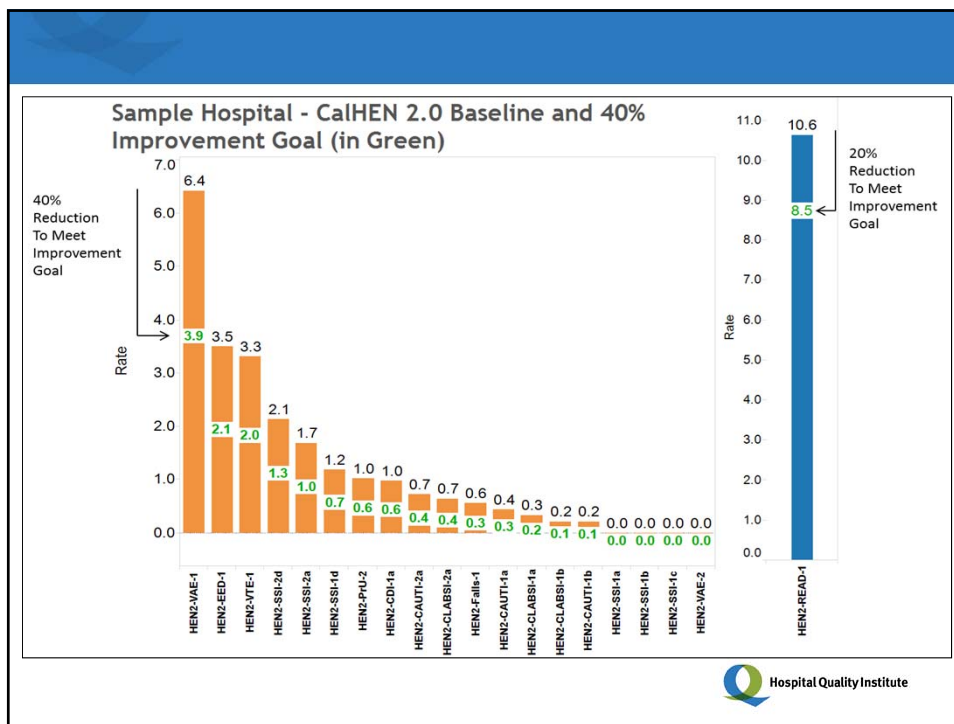
Number of Patients - 117

Diagnosis

- Cancer
- Lunacy
- Dropsy
- Consumption

Metrics

- Cured
- Relieved of symptoms
- Irregular behavior
- Discharged incurable
- Taken away by friends
- Dead
- Left in the hospital



Data Convinces – Stories Compel

- Real people
- Patient stories
- Testimonials
- Listening and learning

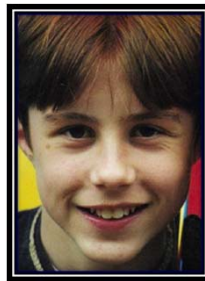
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Personalize Harm

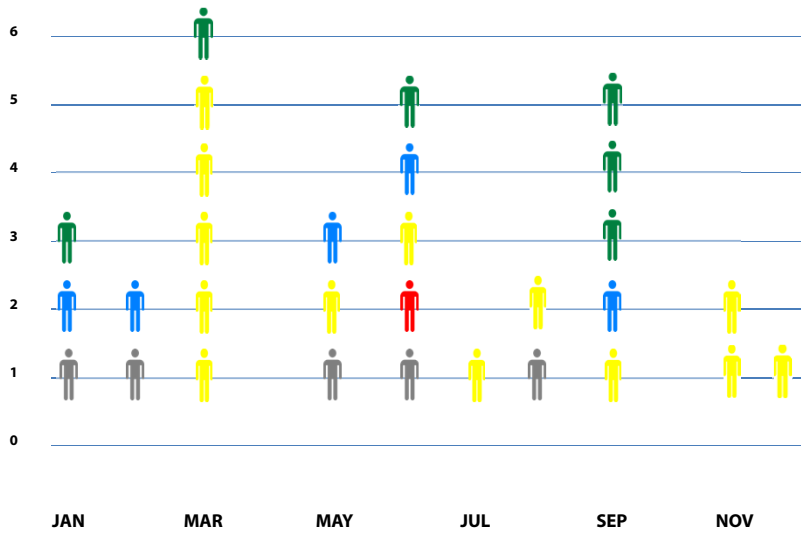
“It is by going down into the abyss that we recover
the treasure.

Where you stumble, there lies your treasure.”

Joseph Campbell
Anthropologist, Journalist
1904-1987



Sample Chart of Serious Safety Events



**Triple Aim: Better Care. Better Health. Lower Cost.
Consider Quadruple Aim: Meaningful Work**



Quadruple Aim

The Quadruple Aim: care, health, cost and meaning in work

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In 2008, Donald Berwick and colleagues provided a framework for the delivery of high value care in the USA, the Triple Aim, that is centered around three overarching goals: improving the individual experience of care, improving the health of populations, and reducing the per capita cost of healthcare.¹ The intent is that the Triple Aim will guide the redesign of healthcare systems and the transition to population health. Health systems globally struggle with these challenges of improving the health of populations while simultaneously lowering healthcare costs. As a result, the Triple Aim, although originally conceived within the USA, has been adopted as a set of principles for health system reform within many organisations around the world.

The successful achievement of the Triple Aim requires highly effective healthcare organisations. The backbone of any effective healthcare system is an engaged and productive workforce.² But the Triple Aim does not explicitly acknowledge the critical role of the workforce in healthcare transformation. We propose a modification of the Triple Aim to acknowledge the importance of physicians, nurses and all employees finding joy and meaning in their work. This 'Quadruple Aim' would add a fourth aim: improving the experience of providing care.

The core of workforce engagement is the experience of joy and meaning in the work of healthcare. This is not synonymous with happiness, rather that all members of the workforce have a sense of accomplishment and meaning in their contributions. By meaning, we refer to the sense of importance of daily work. By joy, we refer to the feeling of success and fulfillment that results from meaningful work. In the UK, the National Health Service has captured this with the notion of an engaged staff that 'think and act in a positive way about the work they do, the people they work with and the organisation that they work for'.³

The evidence that the healthcare workforce finds joy and meaning in work is not encouraging. In a recent physician survey in the USA, 60% of respondents indicated they were considering leaving practice; 70% of surveyed physicians knew at least one colleague who left their practice due to poor morale.⁴ A 2013 survey of British physicians reported similar findings with approximately 40% of respondents reporting very low or low morale.⁵ These findings also extend to the nursing profession. In a 2013 US survey of registered nurses, 51% of nurses worried that their job was affecting their health; 33% felt like resigning from their current job.⁶ Similar findings have been reported across Europe, with rates of nursing job dissatisfaction ranging from 13% to 60%.⁷

The absence of joy and meaning experienced by a majority of the healthcare workforce is in part due to the threat of psychological and physical harm that are common in the work environment. Workforce injuries are much more frequent in healthcare than in other industries. For some, such as nurses' aides, orderlies and attendants, the rate is four times the industrial average.⁸ More dire are lost due to occupational illness and injury in healthcare than in mining, machinery manufacturing or construction.⁹

The risk of physical harm is dwarfed by the extent of psychological harm in the complex environment of the healthcare workplace. Egregious examples include bullying, intimidation and physical assault. Far more prevalent is the psychological harm due to lack of respect. This dejection is compounded by production pressures, poor design of work flow and the proportion of non-value added work.

The current dysfunctional healthcare work environment is in part a by-product of the gradual shift in healthcare from a public service to a business model that occurred in the latter half of the 20th

Re-use: Sikka R, Morath JM, Leape L. BMJ Open 2015;9:e007427. Published Online First: 11 May 2015. doi:10.1136/bmjopen-2015-007427

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National Priorities Partnership Convened by National Quality Forum Durable Issues

1. Engage patients and families in managing their health and making decisions about their care
2. Improve the health of the population
3. Improve the safety and reliability of America's health care system
 - Infection
 - Adverse events
 - Hospital-level mortality rates
 - 30-day mortality rates post hospitalization



National Priorities Partnership (cont.)

4. Ensure patients receive well-coordinated care within and across ALL health care organizations, settings and levels of care
5. Guarantee appropriate and compassionate care for patients with life-limiting illnesses
6. Eliminate overuse while ensuring the delivery of appropriate care



Preconditions: Transparency

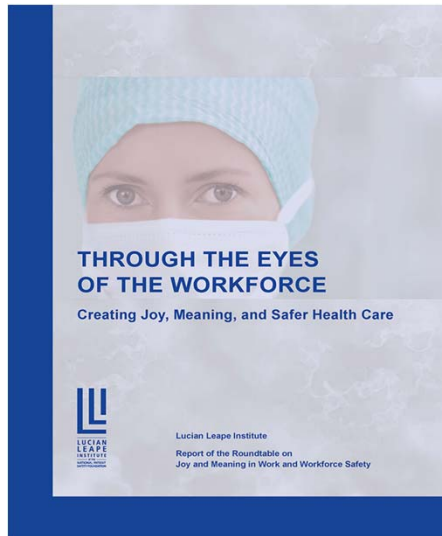


- Practiced value
- Characteristic of a quality culture
- 5 areas of transparency
 - with colleagues
 - with patients/families
 - with governance boards
 - between organizations
 - with public

Source: Lucian Leape Institute Roundtable, National Patient Safety Foundation 2015.
http://c.ymcdn.com/sites/www.npsf.org/resource/resmgr/LL/Shining-a-Light_Transparency.pdf



Pre-Conditions: Respect for People



- Meaningful work
- Opportunities to learn and develop
- Respect and engagement
- Freedom from harm

Source: Lucian Leape Institute Roundtable, National Patient Safety Foundation 2013.
http://www.patientcarelink.org/uploadDocs/1/Through-Eyes-of-the-Workforce_online.pdf



Can Each Person in the Workforce Answer Yes to These 3 Questions Each Day?

1. Am I treated with dignity and respect by everyone each day?
2. Do I have what I need so I can make a contribution that gives meaning to my life?
3. Am I recognized and thanked for what I do?



Simply Stated

- Governance:** Own vision and mission goals.
Require and protect culture of respect, professionalism and excellence.
- Leadership:** Inspire quality and model the way.
Build the system, resource and encourage the heart.
- Management:** Act to make quality live and transform care/operations.
- Frontlines:** Has the information to respond and provide wisdom and energy for transformation.



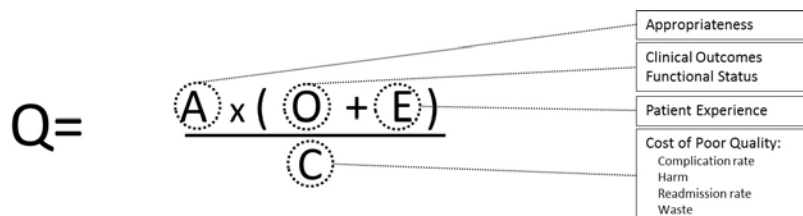
Summary

Quality care is less expensive care.

It is better, more efficient and less wasteful.

It is the right care, at the right time, every time.

It is reliable.





Hospital Quality Institute

Leadership in quality and patient safety

CEO, Leader, and Governance

Quality Work Guide



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Hospital Quality Institute



Thank You


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Questions

Online questions:
Type your question in the Q & A box, hit enter

Phone questions:
To ask a question, hit *1



Upcoming Programs



California Physician Leadership Program

Two days per month, October 2016 – April 2017

The California Physician Leadership Program is a comprehensive educational program designed to challenge and grow physician leaders and medical executives. Participants will learn to assume greater leadership, serve as a driver of change and achieve better outcomes for patients.



Upcoming Programs

Cybersecurity: Emerging Threats to Hospitals Webinar

June 9, 1:30 p.m. – 3:30 p.m., PT

Cyberattacks are on the rise and hospitals are being targeted. Learn what the FBI and other government agencies are doing to protect the nation — and hospitals in particular — from cyberattacks. Identify critical strategies you can implement now to protect your hospital from cyberattacks, as well as steps to take if you become a victim.



CHA Publications

Consent Manual

2016 Edition



The most comprehensive and acclaimed resource available to hospitals regarding patient consent for medical treatment, release of information, reporting requirements and more.

Features a new section on the End of Life Option Act.

Visit www.calhospital.org/consent



Thank You and Evaluation

Thank you for participating in today's seminar.
An online evaluation will be sent to you shortly.

A recording of this program will be available
to all CHA members.

For education questions, contact
Mary Barker at (916) 552-7514 or
mbarker@calhospital.org.

