

Beyond the Front Lines

Why greater openness among clinicians is needed to drive improvement in patient safety.

By Tejal K. Gandhi, MD, MPH, CPPS

Earlier this year, the National Patient Safety Foundation's Lucian Leape Institute released a report calling for greater transparency in healthcare as a means of improving patient safety. Defining transparency as "the free, uninhibited flow of information available to the scrutiny of others," the report argues for transparency across all areas of healthcare: between clinicians and patients; among clinicians; between organizations; and with the public (NPSF Lucian Leape Institute, 2015).

Yet weaving transparency into the fabric of everyday practice is easier said than done. Throughout the year, Institute members have expanded upon this theme in articles, webcasts, and meetings as we address how to do the hard work of implementing practices that can help us achieve greater transparency.

At the Institute's fall meeting in Boston, leaders, researchers, and frontline clinicians discussed the practical challenges to transparency. One bit of consensus from the groups was that getting providers and provider organizations to share data and information is essential for improving patient safety, but it is also one of the most difficult areas in which to make progress.

Leadership at the core

Greater openness between providers has the potential to help us better understand safety risks, spread best practices among peers, and perhaps most important, begin to reduce the shame felt by clinicians when an error occurs, which can then help normalize the reporting of errors and adverse events (NPSF Lucian Leape Institute, 2015). Sharing of data among clinicians—including outcomes and safety data—has largely been

limited to peer review sessions or committee meetings within organizations. Some organizations begin board meetings with storytelling of safety lapses, and others publish newsletters to share safety information among the staff (Kowalczyk, 2013).

Unfortunately, one of the greatest barriers to transparency among clinicians lies in the very culture of the organizations in which they work. So many years into the patient safety movement, we still hear stories of blame or fear of punishment in regard to reporting safety issues.

The most recent results from the Agency for Healthcare Research and Quality's (AHRQ) Comparative Database of Patient Safety Culture cite *nonpunitive response to error* as an "area for potential improvement

physicians, clinicians, and nonclinical staff that reporting safety lapses and near misses is necessary for safety improvement and is expected—and that the goal is to improve systems, not punish individuals. They need to lead the way in making sure the infrastructure and policies exist to facilitate such reporting (Leonard & Frankel, 2012).

The current landscape

One relevant development in the current landscape is the growth of AHRQ's Patient Safety Organization (PSO) network. Created by the Patient Safety and Quality Improvement Act of 2005, the network consists of 81 PSOs in 29 states and the District of Columbia. The program allows healthcare providers to "voluntarily report

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in most hospitals." Fewer than half (44%) of respondents "feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file" (AHRQ, 2014), which would make it unlikely for these frontline respondents to be open and transparent about safety issues.

One of the strongest messages we can send to leaders is that they hold the power to transform their organizational culture. They are in the best position to convey to

information on patient safety events under legal protection and to use this information to develop patient safety interventions and solutions" (AHRQ Patient Safety Organizations, 2015). The data must be reported via AHRQ's common formats to make reporting more uniform and allow for comparative reports back to the members. Participating organizations can also choose to be part of a larger database that can evaluate trends in event-level data (AHRQ Advancing Patient Safety, 2015).

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along with the corresponding risk for safety lapses, physician practices and outpatient centers could potentially benefit from joining a PSO, which provides peer-review protection that they are not otherwise afforded (Gosfeld, 2014).

A transparency checklist for clinicians

In an effort to boost transparency among all parties, the NPSF Lucian Leape Institute is working on a series of transparency checklists that address the kinds of actions that need to become routine. These are not the kind of checklists that we use prior to performing surgery or inserting a central line; achieving transparency is not as straightforward as following a set of standardized rules. The purpose, rather, is to help keep transparency top of mind for everyone in the healthcare system—from leaders and board members to clinicians, patients, and families.

As of January 2017, hospitals with more than 50 beds will be required to join a PSO in order to contract with health plans in the federal insurance exchange programs. Although it is early in the evolution of PSOs, and their effectiveness has thus far been variable, there have been some early successes, such as the Michigan Surgical Quality Collaborative (MSQC), which compiles outcomes data on surgeries from 72 hospitals in the state that agree not to compete on safety. The MSQC conducts risk adjustment and identifies top performers, who then share their practices with their peers. An early success has been a reduction in surgical site infections after colectomy from 12% to 7.5%—the national average being about 13% (National Patient Safety Foundation, 2015). This is an excellent example of the value of transparency between provider organizations and how it can lead to widespread improvement.

Although ambulatory practices are welcome to participate in the PSO program, thus far, specialized treatment facilities and general hospitals make up the majority of members (AHRQ Patient Safety Organizations, 2015). With more care shifting to the outpatient setting,

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Some of the key actions that you can start right away include:

- Commit to transparency with patients and families, all of your professional colleagues, and leaders.
- Become educated and engaged in your organization's programs and initiatives to promote transparency.
- Hold yourself and your colleagues accountable for creating and sustaining a culture of transparency. Thank your peers, colleagues, and students when they speak up about a safety lapse or potential safety issue.
- Communicate any relevant disclosures and conflicts of interest to patients and families, your organizations, your colleagues, and the public.
- Work to create multidisciplinary processes and forums for reporting, analyzing, sharing, and using safety data for improvement.
- Actively use your organization's safety reporting systems for any incidents of error or harm, as well as prospective hazard analysis.

Using transparency to tell your story

In a survey of health professionals who attended a preconference session prior to the NPSF Patient Safety Congress this year, only 15% said they were "satisfied with the degree of transparency in their organization" (National Patient Safety Foundation, 2015).

Clearly, the public is not satisfied, either. In July, the nonprofit news outlet ProPublica released its Surgeon Scorecard, which uses Medicare claims data to rank hospitals and surgeons on complication rates in a small group of relatively low-risk surgeries (Wei et al., 2015). The report sparked controversy, with some in the medical community arguing, among other things, that claims data do not provide the most accurate picture of outcomes.

Yet some of those same critics acknowledged that the report "at least triggered an important discussion about how to do [transparency] right"

(Rosenbaum, 2015). The fact is, if the medical community does not become more transparent about safety and outcomes, others will do this work. We owe it to ourselves and to patients to generate useful data and share it responsibly so that we can

learn from our mistakes and benefit from the experience of our top performers. █

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