Shining a Light: Safer Health Care Through Transparency

A Webinar on the Most Recent Report from the National Patient Safety Foundation’s Lucian Leape Institute
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Shining a Light: Safer Health Care Through Transparency

From the NPSF Lucian Leape Institute Roundtable on Transparency

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Available for download at http://www.npsf.org/transparency
Report Background & Key Recommendations

Robert M. Wachter, MD
Associate Chair, Department of Medicine, University of California San Francisco
Member, NPSF Lucian Leape Institute Co-Chair, NPSF LLI Roundtable on Transparency
Background on the Report

2 roundtable meetings in 2013 and 2014

Invited participants: patient advocates, health systems, quality measurement, risk management, media, government, payer, academic, nursing/nursing leadership, industry, ambulatory, national organizations, research organizations
Report Content

- Research on transparency
- Assessment of barriers
- Recommendations
- Case studies

Does not address transparency of cost data except where relevant to safety and quality
What Is Transparency?

- “The free, uninhibited flow of information that is open to the scrutiny of others.”

- Essential for establishing trust, accountability, ethical behavior

- Necessary first step or precondition

- Relatively inexpensive and effective tool
Need for Transparency

Improved outcomes, fewer errors, more satisfied patients, lower costs
The Four Interrelated Domains of Transparency

- **Between clinicians and patients**
  (e.g., disclosure after a medical error)

- **With the public**
  (e.g., public reporting of safety data)

- **Among clinicians**
  (e.g., peer review)

- **Among organizations**
  (e.g., regional collaboratives)
Transparency Between Clinicians and Patients

Extreme honesty with patients and families, including:

- Shared decision making
- Fully informed consent before treatment
- Free and open communication during care and when things go wrong
Transparency Among Clinicians

Communication related to hazards, errors, adverse events among clinicians to improve care systems

Just culture a precondition (no fear of punishment or embarrassment; no tolerance for recklessness)

Must have effective mechanisms for reporting and analyzing safety events, implementing improvements, providing feedback
Transparency Among Organizations

Sharing safety data among payers, hospitals, vendors, purchasers

- Requires significant cultural shift
- Fear of litigation, loss of peer review protection
- Collaboratives, PSOs
- Storytelling as powerful tool for inspiring change
Transparency to the Public

- Public reporting of harmful events
- Reliable safety data available to the public
- Requires protected environment and safety culture
- Financial pressure both to share and withhold (revenue loss, market share, new payment models)
- Responsibilities of governing bodies
- Transparency around outcomes, not process measures
Barriers to Transparency

- Fears about conflict, disclosure, and potential negative effects on reputation and finances
- Lack of a pervasive safety culture and the leadership commitment needed to create it
- Stakeholders with a strong interest in maintaining the status quo
- Lack of reliable data and standards for reporting and assessing clinician behavior regarding transparency
39 total recommendations

Specific call to action for leaders, CEOs, and boards of healthcare organizations, AHRQ and NQF, accreditation bodies, CMS, etc.

Recommendations fall into the 4 levels of transparency as well as specific recommendations for Leadership and Measurement
What We’re Trying to Promote

Discussion of a 39-Fold Overdose Within and Outside an Organization

The intended dose:
One double-strength Septra

The administered dose:
39 double-strength Septras
The Role of Leadership

Gary S. Kaplan, MD, FACMPE

Chairman and CEO, Virginia Mason Medical Center

Member, NPSF Lucian Leape Institute Co-Chair, NPSF LLI Roundtable on Transparency
Leadership Is Essential to Achieve Transparency

Strong leadership that models honesty and prioritizes transparency is a prerequisite for effective change in this arena.
Leadership Critical in Every Dimension

Need courageous leaders and boards willing to emulate and prioritize transparency in every domain within their organizations.

Strong leadership is essential for establishing and maintaining a culture of safety and for prioritizing transparency at all levels.
Actions for Organizational Leadership: Leaders and Boards of Health Organizations

- Prioritize transparency, safety, and continuous learning and improvement.
- Frequently and actively review comprehensive safety performance data.
- Be transparent about board membership.
- Link hiring, firing, promotion, and leader compensation to results in cultural transformation and transparency.
Investigators: Medical mistake kills Everett woman

Hospital error caused death

Mary L. McClinton
The Patient Experience

Beth Daley Ullem, MBA

Patient Advocate and Governance Expert
Board of Directors, ThedaCare Hospital System and Solutions for Patient Safety
Board of Governors, NPSF
Former Board of Directors, Children’s Hospital of Wisconsin

Member, NPSF Lucian Leape Institute Roundtable on Transparency
A New Era of Patient Partnership

In Good Times…

• Provide Patients Full Information to Understand and Direct our Care

• Involve us as a Partner in Rounds and Notes

• Involve us as a Partner in Hospital Decisions and Oversight

Mac Ullem – age 6
A ‘frequent flyer’
TOF, TEF, Tethered Cord
G and J tubes, freq. pneumonias
A New Era of Patient Partnership

And in Difficult Times…

• End Deny and Defend – New Approaches to Conflict Resolution

• Instead, Acknowledge, Improve and Make Amends (AIM) – early and fairly

• Provide support for clinicians to have difficult conversations and heal after events

Michael Benjamin Ullem Died in October 2003 from Preventable Medical Errors
Q&A
What You Can Do Now to Advance Transparency

- **Share** this report with your executive team and all leaders in your organization
- **Compare** this report to your patient safety plan, and **commit** to implementing the recommendations
- **Prepare** a plan to get started, and **execute** on the plan
- **Publish** your commitment to transparency and a link to this report on your website

http://www.npsf.org/transparency
Thank You

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Johns Hopkins Medicine

The Leapfrog Group

University of Michigan

Virginia Mason

NPSF
Thank You

Download the report at http://www.npsf.org/transparency

Complete the reader survey at https://www.surveymonkey.com/s/LLI2015

Direct questions about the NPSF Lucian Leape Institute or *Shining a Light: Safer Health Care Through Transparency* to lli@npsf.org

Register for the NPSF Patient Safety Congress at www.npsf.org/congress
Appendix – Report Recommendations
Actions for All Stakeholders

1. Disclose all conflicts of interest.
2. Provide patients with reliable, useful information.
3. Present data from 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 core competencies regarding accurate communication with patients, families, other clinicians and organizations, and the public.
7. Prioritize transparency, safety, and continuous learning and improvement.
8. Frequently and actively review comprehensive safety performance data.
9. Be transparent about board membership.
10. Link hiring, firing, promotion, and leader compensation to results in cultural transformation and transparency.
Actions Related to Measurement

**AHRQ and NQF:**

11. Develop and improve data sources and mechanisms for collection of safety data.

12. Develop 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.
Actions Related to Measurement

**Accreditation Bodies:**
14. Work with CMS, AHRQ, and HRSA to develop measures of care that matter to patients and clinicians across all settings.

**CMS:**
15. Require public performance data as condition of participation in Medicare or Medicaid.

**All Parties:**
16. Ensure data source accessibility 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 full description and pros and cons of all alternatives for tests and treatments.
18. Inform patients of clinician experience, outcomes, and disciplinary history.
19. Inform patients of trainee roles in 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.
Actions to Improve Transparency Between Clinicians and Patients

CEOs, Other Leaders, Clinicians:

*During Care*

22. Provide patients 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.
Actions to Improve Transparency Between Clinicians and Patients

**CEOs, Other Leaders, Clinicians:**

*After Care*

25. Promptly provide patients and families full information about 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 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 Medicare, and liability insurers:**
36. Provide resources for state and regional collaboratives.
Actions to Improve Transparency to the Public

Regulators and Payers:
37. Ensure all health care entities have core competencies to accurately and understandably communicate their performance to the public.

38. Ensure health care organizations publicly display measures used for monitoring quality and safety (dashboards, organizational report cards, etc.).

Health System Leaders and Clinicians:
39. Make it a high priority to voluntarily report performance to reliable, transparent entities (e.g., state and regional collaboratives, national initiatives and websites).