

Leadership Day 2015

Executive Summary

Shining a Light: Safer Health Care Through Transparency

Pre-Congress Session
17th Annual NPSF Patient Safety Congress
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The Leadership Day Pre-Congress Session entitled, “Shining a Light: Safer Health Care Through Transparency” took place on April 29, 2015, at the National Patient Safety Foundation’s 17th Annual Patient Safety Congress.

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About This Program

The idea for this program evolved from a report of the same name by the NPSF Lucian Leape Institute. *Shining a Light: Safer Health Care Through Transparency* (2015) defines transparency as “the free flow of information that is open to the scrutiny of others,” and makes the case for greater transparency across four domains of health care:

- Between clinicians and patients (for example, by disclosure after medical error)
- Among clinicians (for example, peer review and other mechanisms to share information within a health care delivery organization)
- Between health care organizations (for example, through regional or national collaboratives)
- Between clinicians/organizations and the public (through public reporting of quality measures)

This session’s goal was to examine the importance of transparency as it relates to improving patient safety. The faculty addressed the premise that greater transparency throughout the health care system will lead to improved outcomes, fewer errors, more satisfied patients, and lower costs. The session also touched upon how transparency can support accountability, stimulate improvements in quality and safety, promote trust and ethical behavior, and facilitate patient choice.

The program was organized into the following areas of discussion:

- I. Transparency with Patients and Families
- II. Transparency Across Organizations and Between Providers
- III. Case Studies: The Pros and Cons of Public Transparency
- IV. Transparency in a National System: Lessons from the National Health Service, England

Attendees of this interactive program included patient safety officers, risk managers, and quality executives; chief nursing officers; chief medical officers; and others.

The following is a summary of the presentations.

I. Transparency with Patients and Families

Rick Boothman, JD, opened the session by reading the following statement as a guiding principle of the program:

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.

Through patient stories and a video, co-chairs James Anderson, JD, and Boothman emphasized the importance of making patient and family concerns the top priority in any situation where an adverse outcome or a medical error has occurred. Historically, Boothman said, cases of medical error or adverse events have been handled by lawyers in ways designed to protect the organization from medical malpractice liability, too often at the expense, unfortunately, of the myriad other concerns that arise from patient injuries. Clinical staff were discouraged from discussing safety lapses in an unprotected environment, and were even counseled to not change their processes, because that could complicate defense of a potential claim by suggesting, after the fact, that something could have been done better or more safely.

Boothman said transparency is necessary to improvement because “you can’t fix a problem until you acknowledge you have one. . . .” Moreover, he said that health care organizations have largely underestimated the degree to which patients and their families who have been injured by medical mistakes feel responsible for helping ensure that the same thing does not happen to another patient.

The Michigan Model

The claims process put in place by the University of Michigan Health System is based on three principles:

When an adverse event occurs:

1. It is our ethic and culture to do our best to compensate quickly and fairly if the injury was caused by unreasonable medical care.
2. If the care was reasonable under the circumstances, we owe our caregivers full support. The caregivers and the patient need to be served by honesty in all cases.
3. We should learn from our experiences and hard-wire improvement into these situations.

Analysis of the Michigan Model has shown, contrary to the predictions that honesty would lead to financial catastrophe, that the system has experienced reductions in medical malpractice claims, in total liability costs, and in mean liability costs over the 14 years since this approach started there (Kachalia et al. 2010). These reductions have been sustained even while clinical activity continues to grow.

Boothman said he truly believes the organization is providing safer care than before, because “we’re not dealing with the same problems we used to see.” More important, he said, incident reporting has increased, and greater openness has led to robust quality and safety efforts, a stronger peer review process, and changes in corporate structure.

The Massachusetts Experience

The Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI), began with a grant from the Agency for Healthcare Research and Quality (AHRQ) and a quest to determine whether the Michigan Model could work in Massachusetts. Presenter Kenneth Sands, MD, said the grant allowed him and his colleagues to interview stakeholders, look at the barriers to such a program, and explore how best to overcome those barriers.

The Massachusetts team partnered with organizations such as the Massachusetts Medical Society, the Massachusetts Bar Association, the Massachusetts Association of Trial Attorneys, and other diverse stakeholders. MACRMI functions as a centralized location for resources that it promotes and disseminates through its website, www.macrmi.org. Among the materials available are algorithms for structuring how conversations occur and the potential outcomes of such conversations as well as a classification system for outcomes.

Key elements that have helped the MACRMI program and its pilot sites succeed are:

1. Leadership: It is vital to establish support within institutions, and it helps when the community (of other MACRMI stakeholders) confirms that this is the right thing to do.
2. Culture: A baseline culture of safety, where reporting is encouraged, is necessary for success.
3. Staff: Have a commitment from the risk management and patient safety departments to move forward, with a staff person (sometimes reassigned from one of those areas) to manage the program.
4. Support: This includes patient resources, peer support for clinicians, and the support of the larger community of like-minded institutions.

The presenters emphasized that transparency is not a one-size-fits all solution. Different organizations in different states with different legal concerns need to adapt to do what works for them.

II. Transparency Across Organizations and Between Providers

The second part of the program presented three examples of transparency between providers and provider organizations, with speakers James Anderson, JD, James Fuller, PharmD, and Michael Englesbe, MD.

Cincinnati Children's Hospital

With a Pursuing Perfection grant from the Robert Wood Johnson Foundation, Cincinnati Children's Hospital (CCH) committed to full transparency with patients. Under Anderson's leadership, they began publicly reporting safety data, formed patient and family committees, and instituted family rounding.

Anderson presented 7 strategies that he considered essential to the success of CCH in practicing transparency.

1. **Have a compelling vision.** CCH leaders settled on a vision to "be the leader in improving child health." It was simple, aspirational, and limitless. Ground all initiatives in the vision and use it to raise the bar.
2. **Collect, analyze, and disseminate data with a robust, respected data component.** In the clinical world, data is relevant, compelling, and essential. To start, CCH hired a PhD statistician and conducted conversations with clinical staff about what projects to move forward, how to measure success, and what mechanisms needed to be in place to improve. The group grew as the program grew.
3. **Design, implement, and utilize a management system.** CCH created business units at the divisional level so that the disciplines would work together and decisions could be made "as close to the patients as possible." Physicians, nurses, and business people on these teams worked together on plans and budgets. They met 3 times per year with institutional leaders, staff representing the organization's infrastructure, and those representing the medical hierarchy to ensure progress and provide resources. The teams used standard templates to report on plans, which, made the process predictable and efficient. With regular meetings and template reporting there was no place for any participant to hide from engagement in advancing critical initiatives.

4. **Develop and install follow-up systems.** Have a mechanism to keep good ideas visible, and allocate the resources necessary to benefit from them. In one example, CCH changed the way they performed root cause analysis: the general counsel's office handled the process; clinicians, relieved of the procedural side, handled the substance, and the results proved more useful and effective. They also conduct audits 2 years after an RCA to ensure that changes made are having the desired effect. Hard-wired mechanisms to sustain agreed upon changes in practice are essential to benefiting from those changes.
5. **Develop and install mechanisms that require transparency.** At CCH, information about critical metrics, safety, performance, and outcomes is posted widely, on the website, on the intranet, in hallways, in clinical units. On the intranet, a "safety tracker" shows the number of days since the last serious safety event and the last employee injury that resulted in lost time. Adverse events are discussed with their Patient and Family Advisory Councils, and they created a Patient Care Committee of the board of directors, and every board member is required to participate for some time. Each board meeting starts with a safety report.
6. **Upgrade the infrastructure.** Data collection and analysis is a key part, but Anderson recommended developing internal experts in Lean, Six Sigma, PSDA or some quality improvement system to "make it easy for any leader to make radical change," by giving them access to the resources needed to improve.
7. **Build trust.** It's important to practice mission and message integrity. Do what you promise. Leaders at every level need to hold to their commitments.

Indianapolis Coalition for Patient Safety

The Indianapolis Coalition for Patient Safety, Inc., is a not-for-profit organization founded in 2003 by leaders of 6 diverse health care provider organizations in Marion County, Indiana, that all agreed to share best practices and not to compete on safety. In addition to the member hospitals, the coalition has an extensive network of community partners, such as the county health department, insurers, manufacturers, the local health information exchange, Indiana Hospital Association, as well as medical, pharmacy, and nursing schools and the local quality improvement organization.

Presenter James Fuller, PharmD, explained the organizational structure of the coalition:

Board of Directors: Made up of the 6 CEOs of the member organizations, this group provides governance and overall direction. Each year they sign a letter of membership to recommit to working as a community to improve safety, which affords peer protection for workgroups.

Executive Work Group: Made up of chief nursing officers, chief medical officers, pharmacy leaders, and quality and safety leaders for each member organization, this group meets every other month to give direction and set priorities. This is the group that decides which projects to undertake and they recruit the content experts from their organizations.

Initiative-Specific Work Groups: These groups are interdisciplinary teams of subject matter experts who review the literature on the topic at hand, present best practices, and conduct surveys of current practices in the member hospitals. This group determines and recommends best practices for the coalition members as well as how success will be measured.

Fuller said there are currently about 14 initiative-specific work groups in progress. Among the examples of recent work are:

- The “Common Cause” workgroup, which includes risk managers from the member organizations, conducts meetings with full transparency regarding adverse events. They share stories, review root cause analyses from members, and discuss and share results.
- The Flu Policy/Guidelines Workgroup looked at initiatives to prevent the spread of hospital-acquired flu, including mandatory health worker vaccination. In this case, the coalition developed policy guidelines and an implementation guide and plan. Staff vaccination rates improved from 59% in 2011 to 95% in 2012 and 100% in the following years.

In conclusion, Fuller said that the Indiana Hospital Association has worked to replicate the structure of the coalition, and that there are now 11 such entities across the state that bring hospitals together regionally to share and learn from each other.

Michigan Surgical Quality Collaborative

The Michigan Surgical Quality Collaborative (MSQC) was founded in 2005 with funding from Blue Cross Blue Shield of Michigan, the largest private payer in the state, and in 2013 received the designation of a Patient Safety Organization by the Agency for Healthcare Research and Quality. Presenter Michael Englesbe, MD, said surgeons have a strong relationship with the insurer and they share a goal of making surgery safer and augmenting value.

The 72 participating hospitals agree to not compete on safety. Members of the collaborative are expected to share their expertise regarding what they do well. One of the collaborative’s main functions is to serve as a registry for data that are risk adjusted to more fairly compare hospitals and surgeons. The registry systematically identifies top performers, who are then asked to tell the others how they achieve the best outcomes.

As part of the collaborative, Blue Cross Blue Shield also funds physician-led quality teams in different domains of care (for example, cardiothoracic surgery, interventional cardiology, breast cancer, emergency medicine). In the area of surgical site infections after colectomy, for example, where the average rate in the US is 13%, Michigan hospitals in the MSQC saw a reduction from 12% to 7.5%

Blue Cross Blue Shield estimates that the improvements coming out of the workgroups translate into a 3 to 1 return on investment, or a savings of about \$40 million per year.

III. Case Studies: The Pros and Cons of Public Transparency

This session featured attendee participation through polling questions and exercises to get them thinking about issues related to transparency. Marshall Allen moderated the session and provided commentary along with Lisa McGiffert and Allen Kachalia, MD, JD.

To set the stage for the discussion, Marshall Allen began the session by asking attendees to respond to a number of questions via multiple choice answers (see tables 1–4 on page 10).

To further fuel the discussion, Allen asked attendees to agree or disagree with the following statements:

1. It's never okay to withhold the full truth about a medical error from a patient.
2. If the medical community won't become more transparent voluntarily, then transparency needs to be imposed on it.

Allen called upon some attendees to explain their positions, with the following themes emerging:

- We should probably never withhold the truth if harm has resulted or will result, but how information is relayed to the patient is important.
- Part of the way to eliminate the barriers to transparency is to require organizations to practice it; only then will they see that their fears do not come to fruition, but good things do.
- Some felt that mandating transparency could backfire, leading to less reporting of errors within an organization.
- Some worried about doing more harm than good if bad or inaccurate information is reported.

Table 1. The biggest barriers to transparency are:

	Responses
Fears about conflict and the potential negative effects on reputation and finances	53%
The lack of a pervasive safety culture and leadership commitment	31%
Stakeholders with a strong interest in the status quo	8%
A lack of reliable data for assessing performance and standards for reporting	8%
Other	0%
Total	100%

Table 2. At my medical facility, patients are always told if they were the victim of a medical mistake, whether they knew about the mistake, or not.

	Responses
Strongly Disagree	17%
Disagree	31%
Neutral	12.5%
Agree	27%
Strongly Agree	12.5%
Total	100%

Table 3. A health care system that embraces transparency will ultimately produce safer care, better outcomes, and more trust.

	Responses
Strongly Disagree	6%
Disagree	2%
Neutral	0%
Agree	19%
Strongly Agree	73%
Total	100%

Table 4. I'm satisfied with the degree of transparency at my medical institution.

	Responses
Strongly Disagree	16%
Disagree	46%
Neutral	16%
Agree	20%
Strongly Agree	2%
Total	100%

The session then moved into discussion of scenarios based on actual events.

Case Scenario 1: Numerous outbreaks of deadly CRE (carbapenem-resistant Enterobacteriaceae) infections connected to contaminated duodenoscopes made headlines this year. Investigations revealed hundreds of patients were exposed, some getting infections, others dying, others possibly colonized. It became clear that hospitals, the manufacturers, the US Food and Drug Administration (FDA), and the Centers for Disease Control and Prevention (CDC) knew that the manufacturers' cleaning instructions were not adequate.

- The majority of attendees (91%) agreed that: "Patients should always be notified if a hospital identifies an outbreak, including those who underwent the procedure and those coming to the hospital for the same procedure."
- A smaller majority (73%) agreed that: "The public should be notified about outbreaks as soon as they are recognized by the hospital."

In commenting on this scenario, Kachalia noted a big challenge to transparency: the hospital that identified the problem was proud of their investigatory work, but it translated in the media to very bad news. Moreover, while contacting past patients about a likely risk is clearly the right course, what is the right course if there is no risk?

McGiffert said that both future and past patients need to be told because the knowledge helps them ask the right questions and educates the public about what the hospital is doing to prevent infections. Because these issues are not normally publicly discussed, the public is shocked when they do hear about them

McGiffert said the recent CRE issue became a problem because our oversight systems along the way broke down. The hospitals knew there were issues, the manufacturers knew, the FDA knew, and the CDC knew. "There is a difference between publishing it in the MMWR [the CDC's Morbidity and Mortality Weekly Report] and posting it prominently on a website," she said. "They all knew but didn't warn the public."

Case Scenario 2: ProPublica has been analyzing years of Medicare data to examine complication rates associated with common elective surgeries, such as knee replacements. They plan to publish risk-adjusted complication rates for surgeons and hospitals across the country. Preliminary findings show that in some cases surgeons with the worst complication rates are operating alongside those with the best.

- The majority (80%) of attendees agreed that the risk-adjusted complication rates of hospitals should be made available to patients and the public for all common medical procedures.

- A smaller majority (70%) of attendees agreed that the risk-adjusted complication rates of surgeons should be made available.

The discussion that followed from this scenario largely centered around the limits of the science of adjusting for risk.

- In comparing individual surgeons, the numbers of patients seen often are not high enough to accurately adjust for risk.
- Comparing hospitals, however, allows for larger numbers and better ways to aggregate data.
- A chief concern was the question of whether surgeons or hospitals would avoid caring for the sickest patients, knowing that, with less-than-perfect methods of risk adjustment, doing so would likely impact their standing among peers.

In answer to a question about ProPublica's work, Allen encouraged health professionals to talk to the media, because most journalists "want to get the story right."

In closing, Allen repeated a question from the start of the session: Only 15% of attendees said they were satisfied with the degree of transparency in their organizations, down 7% from the start of the session.

IV. Transparency in a National System: Lessons from the National Health Service, England

The final presentation of the day featured speaker Michael Durkin, MD, discussing the safety and transparency journey of England's National Health Service.

The NHS currently shares a wide range of data publicly, including process and outcome data for an increasing number of priority areas. This includes surgeon-level data from national clinical audits of 12 specialties. The My NHS website (www.nhs.uk/mynhs) provides data from all hospitals in the country that provide NHS commissioned care.

The NHS's National Reporting and Learning System currently collects in excess of 1.6 million patient safety incident reports a year from NHS staff. Of these incidents, 90,000 are reported to have caused moderate harm; with 6,500 signaling severe harm or death (3,500). This system now holds the largest collection of safety reports in the world, which currently stands at almost 11.5 million since it was launched in 2003. The annual number of incidents reported continues to grow each year.

Staff surveys are an important tool for assessing the safety culture. The NHS collects and publishes a national staff survey (www.nhsstaffsurveys.com). The latest poll (February 2015) showed:

- 85% of staff felt encouraged by their organization to report errors, near misses and incidents.
- 93% of NHS staff know how to report any concerns about unsafe clinical practice.
- But only 68% would feel secure raising these concerns.
- Only 57% would feel confident that their organization would address the concern.

Recent Recommendations and Reports

A series of reports and reviews over the past few years have presented new recommendations for the NHS around transparency and safety (Keogh 2013, The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013, National Advisory Group on the Safety of Patients in England 2013).

As a result:

- The NHS re-launched a Patient Safety Alerting System (www.england.nhs.uk/ourwork/patientsafety/psa/national-psa-system/) with new features to enable the rapid spread and deployment of resources to deal with identified risks and to share best practices.
- Data on every reported never event are now published on a monthly basis. Because the numbers are so small, however, there continues to be concern that patient-level information could be extracted.
- A National Patient Safety Collaborative program has been created with 15 learning systems across the country working together to support the 60 million population in every sector and every setting on safety best practices.
- The NHS created a safety improvement fellowship program, which will recruit 5,000 participants over the next five years, and support them to learn more about quality and safety improvement science and to share their expertise with others.

In March 2014, the Royal College of Surgeons in England published a report called *A Culture of Candour* (Dalton and Williams 2014), which outlines several recommendations to improve transparency within the system. Recommendations include training and support of staff to disclose information about unanticipated events in a patient's care and to apologize when appropriate; improve levels and accuracy of reporting patient safety incidents so that this information is used as the basis for organizational learning and not for individual criticism; and closing the audit loop by spreading and applying lessons learned into practice and publicly report them.

An independent review was also conducted to assess the ability of individual staff members to raise concerns about safety issues within the NHS. A report (Francis 2015) resulting from this review provides 20 recommendations for ensuring that NHS staff are encouraged and protected in speaking up by creating an open and honest reporting culture.

Also this year, a parliamentary select committee recommended (House of Commons Public Administration Select Committee 2015) the creation of a new, independent patient safety investigation system to facilitate investigations via three key elements:

1. A safe space, protecting patients, their families, clinicians, and staff, so they can talk freely without fear of reprisals.
2. Independence from providers, commissioners, and regulators, in order to discover how the system as a whole contributed to the failure.
3. Transparency and accountability: to drive learning and improvement, findings and recommendations must be shared publicly.

Conclusion

This Leadership Day Pre-Congress Session, “Shining a Light: Safer Health Care Through Transparency,” provided compelling stories and evidence to support increased transparency at all levels of health care in order to:

- Build trust between clinicians and patients, and give patients the information they need to make informed decisions about their care
- Make every adverse event a learning experience that is shared with peers so that all can improve
- Drive improvements, safer care, and better outcomes that will lead to greater efficiencies
- Encourage health care systems and organizations to partner with the media to help educate and inform the public.
- Provide the public with information about overall safety, quality, and outcomes, which in turn will help build trust and make the public more aware of the challenges faced by health care organizations and the efforts they put into safety

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