Learning System: Transparency

by Capella Healthcare

WHAT'S COVERED

In this lesson, you will learn about the first component of learning systems: transparency. Specifically, this lesson will cover:

1. Definition
2. Progress
3. Challenges

1. Definition

What if you had a magic solution that could remedy many of the problems of patient safety, healthcare quality, patient engagement, and healthcare cost? It would be inexpensive, available for use today, and so effective that the chance of resistance was low—would it be widely adopted?

The solution is **transparency**. In 2015, the report from National Patient Safety Foundation's Lucian Leape Institute, called *Shining a Light: Safer Health Care Through Transparency*, defined transparency as "the free, uninhibited flow of information that is open to the scrutiny of others." The report specifies four domains of transparency:

- Transparency between clinicians and patients (disclosure after medical errors—describing what happened and how to prevent it)
- Transparency among clinicians (peer review and other information sharing—no fear of giving suggestions, identifying problems, or providing feedback)
- Transparency of healthcare organizations with one another (regional or national collaboratives—sharing good practices and applying lessons learned)
- Transparency of clinicians and organizations with the public (public reporting of quality and safety data—allowing patients to make informed decisions and access care easily)

HINT

In this course, the term "clinician" refers to individuals who participate in direct patient care, such as physicians, nurses, medical assistants, pharmacists, respiratory therapists, and surgical assistants.

Evidence from the report indicates 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 abundant and include the ability of transparency to support accountability, stimulate quality and safety improvements, promote trust and ethical behavior, and facilitate patient choice. The report includes dozens of specific recommendations for clinicians, healthcare organizations, and policymakers, as shown in the table below.

Target of recommendation	Recommendation
All Stakeholders	Ensure disclosure of conflicts of interest and provide patients with reliable information in a form that is useful to them. Create organizational cultures that support transparency, shared learning, and core competencies regarding communication with patients and families, other clinicians, and the public.
Leaders and Boards	Prioritize transparency and safety and frequently review comprehensive safety performance data. Link hiring, firing, promotion, and compensation to results in cultural transformation and transparency.
Governmental Agencies	Develop data sources for collection of safety data, improve standards and training materials for core competencies, and develop an all-payer database and robust medical device registries.
Clinicians	Inform patients of clinician's experience, conflicts of interest, and role in care and provide patients with a full description of all the alternatives for tests and treatments and the pros and cons of each. Provide patients with full information about all planned tests and treatments.
Hospitals and Health Systems	Provide patients with full access to their medical records and include patients and family members in interdisciplinary bedside rounds.
Hospitals and Health Systems, Health Professionals	Provide patients and families with full information about any harm resulting from treatment, followed by an apology and fair resolution. Provide patients and clinicians support when they are involved in an incident. Include patients and family members in event reporting and in root cause analysis.
Hospital and Health Leaders	Create a safe, supportive culture in which caregivers can be transparent and accountable to each other. Create multidisciplinary processes and forms for reporting, analyzing, and sharing data. Create processes to hold individuals accountable for risky or disruptive behavior.
Healthcare Organizations, Hospital Associations, Patient Safety Organizations (PSOs)	Have clear mechanisms for sharing and adopting best practices, for example, by participating in state and regional collaboratives.
Hospitals and Healthcare Organizations	Report and publicly display measures used to monitor quality and safety and clearly communicate to the public about performance.

Gary Kaplan, CEO of Virginia Mason, believes it is impossible to have complete transparency with patients without first developing a strong culture of internal transparency across the organization. When team

members are open and honest and trust each other, without fear, trusting relationships, collaboration, and sharing of best practices will follow. This is where safety culture is linked to the learning system, and the two must work in harmony to be successful. Leaders must institute a Just Culture with psychological safety, as discussed in the Safety Culture course.

TERM TO KNOW

Transparency
Openly sharing data and other information concerning safe, respectful, and reliable care with staff, partners, and families

2. Progress

Today, the plea for greater transparency in healthcare is growing louder from consumers and policy-makers. Pro Publica's recent Voices of Patient Harm project showed that patients and family members strongly desire transparency. The American Hospital Association and the American Medical Group Association have also argued that transparency should drive quality efforts. Today's consumers are posting online reviews of their physicians, care teams, and healthcare organizations on social media. Patient experience data is posted at the service or physician level by some healthcare systems.

The rise of Patient Safety Organizations and the 2005 Patient Safety and Quality Improvement Act increased transparency between clinicians and healthcare organizations. A growing number of Early Resolution Programs have increased transparency between clinicians and patients regarding adverse events in reaction to mounting evidence that prompt disclosure and apology following an injury can decrease medical malpractice and improve satisfaction.

Unlike virtually all other safety interventions attempted to date, the results of transparency efforts have surpassed expectations, both in terms of improved performance and fewer "side effects." For instance, the Center for Medicaid and Medicare Services (CMS) began reporting clinical data on the "Hospital Compare" website, and their report led to plummeting rates of early elective cesarean sections after implementation of a strategy of transparency and payment reform. Similarly, public reporting of patient experience data has led to significant improvements in performance. In fact, there is little evidence that pay-for-performance, a complicated and fraught intervention, works better than simple transparency.

3. Challenges

While transparency is powerful, it does have potential down sides. It requires an appropriate environment to support its use. Everyone must be confident that the data being shared is scientifically validated and accurate. Further, transparency in healthcare is more than merely reporting on required quality and safety metrics. Significant barriers exist to achieving it, including concerns about patient privacy, data integrity, the burdens of collecting and analyzing data, and medical liability.

If people believe they will be treated unfairly after their errors are publicly disclosed, it can be difficult to create environments where clinicians feel they can be open with each other about their errors within organizations. These tensions are real and can't be ignored; instead, they must be forthrightly addressed by

institutional and policy leaders.

Four barriers were found to be especially formidable:

- Fears about conflict, disclosure, and potential negative effects on reputation and finances
- Lack of a pervasive safety culture and leadership commitment to create it
- Stakeholders' determination to maintain the status quo
- Lack of reliable data and standards for reporting and assessing clinician behavior regarding transparency

BIG IDEA

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. It is an essential requirement for patient safety.

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Support

If you are struggling with a concept or terminology in the course, you may contact **RiskManagementSupport@capella.edu** for assistance.

If you are having technical issues, please contact **learningcoach@sophia.org**.

TERMS TO KNOW

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