MASSACHUSETTS
HEALTH CARE SAFETY & QUALITY
CONSORTIUM

MASSACHUSETTS ROADMAP TO HEALTH CARE SAFETY

Task Force: Measurement and Transparency

Final overview July 2023

BETSY LEHMAN CENTER
for Patient Safety

Purpose

The Measurement and Transparency task force was charged with developing recommendations, tools and policy proposals to advance the *Roadmap to Safety* vision that providers, payers, and state agencies collect, analyze, and publish meaningful safety data. This data should include information from patients and families and support the transformation of the health care system into one that proactively recognizes and addresses the underlying causes of harm and enables patients to engage in safety improvement activities.

The Task Force recommendations are intended to have potential for high impact, rely on best practices when possible, and include clear objectives and goals. They should support and be applicable to health care organizations of all types and sizes. They are also intended to help stakeholders including government, payers, liability insurers, and professional associations have the data they need to provide appropriate system supports to provider organizations.

Background

The ability to monitor health care safety risks and to understand their impacts on diverse patient populations, clinicians and staff remains limited despite existing performance and quality measures in provider contracts and mandated reporting to government agencies. There also is no common understanding of what metrics might help advance safety at either the provider or the system levels. While information alone is not enough to ensure health care safety, it is an indispensable driver of improvement.

Health care safety information is siloed across organizations, including data submitted to state or federal government, accrediting bodies, and confidentially shared among peer provider organizations through voluntary quality improvement activities. Other data is held by provider organizations from reports submitted by clinicians, staff, patients and families. Some provider organizations also are beginning to use health information technology, including electronic health records, to monitor to safety risks and events.

VISION

The Measurement and Transparency Task Force envisions a future where there is a set of essential questions that, when answered, will allow Massachusetts providers, policymakers and the public to consistently and reliably assess the status of health care safety statewide. Every safety measurement program is aligned with these questions and collects only meaningful safety data to measure safety outcomes and identify inequities in safety. Provider organizations across the care continuum have internal processes to exchange safety information among all internal stakeholders, actively participate in collaborative learning opportunities, and adhere to state and federal safety reporting requirements. Massachusetts state agencies, in consultation with provider organizations and other stakeholders, harmonize and optimize their health care safety reporting systems and developed mechanisms for providing timely and useful data with other agencies, providers, payers, and the public. Finally, patients and families have easy access to meaningful information about health care safety to make informed choices, reduce the risk of harm in their own care, and contribute to their providers' safety improvement efforts.

Challenges

Current health care safety information is too inconsistent or incomplete to support the system-wide transformation that is necessary for sustained safety improvement.[1] Provider organizations lack effective internal adverse event or near miss detection mechanisms. Frontline clinicians and staff may not have the training and knowledge to recognize preventable harm events or near misses and may not report these events because of competing demands on their time, skepticism about the likelihood of action, fear of reprisal[2], or concerns about legal or reputational consequences. Patients may be reluctant or face barriers to sharing their observations with providers or others. And state and federal reporting systems, designed to collect data for only a small subset of safety risks associated with a narrow group of providers are subject to variable participation and reporting bias and are not structured to meet the informational needs of different stakeholder groups, particularly patients.[3]

What safety data is collected often is not shared within or across organizations.[4] As a result, providers, regulators, and policy makers lack access to information that could help them identify and prioritize safety challenges, support continuous improvement, and enforce accountability. Patients' informational needs when choosing providers, minimizing the risk of harm when receiving care, or engaging in improvement work are not being met. And health plans do not have the data they need to drive safety improvement through mechanisms available to them such as value-based provider contracts and networks.

Finally, designing or selecting measures has its own challenges. No single set of measures will satisfy the needs of every stakeholder and it is not feasible to measure every aspect of safety. [5] In addition, the measures that are available have limitations such as reporting bias, inadequate risk adjustment,[6] and a lack of stratification by factors such as race, ethnicity, age, disability, sex, gender, and socioeconomic status.

Guiding principles

The Consortium encouraged Task Force members to keep the following principles in mind.

- Move the health care system toward a mindset of zero tolerance for defects that can result in physical or emotional harm to patients, families and staff;
- Support approaches to continuous, proactive safety improvement that break down siloes and enable all stakeholders — including provider organization staff at all levels, patients, payers, and policymakers and regulators — to carry out their respective roles;
- Promote a "just culture" by adopting a fair and consistent approach to safety improvement that fosters psychological safety and holds leadership accountable for breakdowns and shortfalls;
- Advance health equity through the elimination of disparities in safety and quality outcomes on the basis of race, ethnicity, language, age, disability, sex, gender, language, and economic factors;
- Encourage an approach to health care and safety that maximizes the benefits of co-production, recognizing that patients and families provide expertise essential to person-centered care;
- Reduce low-value administrative burdens;
- Remove all forms of waste from work, making it easier to do the right thing.

In addition to the above principles, the Task Force followed the Principles for Measuring Safety as derived from *The Salzburg Statement on Moving Measurement into Action: Global Principles for Measuring Patient Safety (2019).*

- Measures focus on information that matters to provider organizations, the public, policymakers, and payers and are dynamic enough to meet stakeholders' evolving informational needs;
- Measures are designed to support and incentivize improvement while minimizing the possibility of ineffective actions and other unintended consequences that can impede patient care and progress on safety;
- Measures are evidence-based when possible, but an inability to apply scientific methods should not prevent provider organizations from testing and adopting measures identified through their own experience;
- Measures capture timely information that reflects current conditions and can be used proactively to prevent harm;
- Measures exist for settings across the continuum of care and cover the entire trajectory of a patient's health experience;
- Measures can be used to identify disparities in safety outcomes by key demographic characteristics so as to advance health equity;
- Measures are appropriately scaled to different care settings, and resource and cost-effectiveness are considered when adding new measures, reducing the burden of measurement;
- Members of the public are meaningfully engaged in the design of measures alongside providers and other stakeholders, and measures reflect a person-centered approach to care and safety; and
- Measures and data collection systems continuously evolve and adapt to maintain relevance, reliability and efficiency.

Discussion points

Below are the main discussion themes and deliverables that resulted from the Task Force's work.

Internal measurement and transparency (within provider organizations)

- List of key settings for measure development:
- Set of core measures on outcomes, processes, and structures for key settings
    - Key settings that crossover into the three completed
    - Key settings that are next
    - Self-assessment tools

External measurement and transparency (between provider organizations and the public)

- Audiences of public-facing safety information and the purposes of transparency for each of these audiences (transparency one-pager)
- Criteria for public-facing dashboards and other information
- Measure sets to include in public-facing dashboards — convo to continue but main talking points below

Optimization of external systems (for information gathering and data sharing)

- Table of contents for an annual progress report on health care safety in Massachusetts
- Inventory of current public and private sources/holders of health care safety data in Massachusetts
- Action plan for a process to optimize and harmonize safety data systems and reporting requirements, including:

- Data collection
  - Eliminating redundant or low-value state reporting requirements
  - Filling critical gaps in safety data collection, including those related to disparities in safety outcomes across different patient populations
  - Streamlining reporting processes
  - Motivating provider participation in reporting systems
- Data sharing
  - Eliminating unnecessary safety data silos across state agencies
  - Increasing access to actionable safety data collected by non-government stakeholders (e.g., health plans, liability carriers)

Next steps

What success looks like

- Massachusetts has a coherent approach for collecting, synthesizing, and disseminating timely, actionable information about safety that supports consumer choice and continuous improvement in all health care settings, while minimizing administrative burden, and enables:
  a. Provider organizations to benchmark their safety processes, structures, and outcomes against peer organizations in support of their internal continuous improvement goals;
  b. Payers to align incentives with safety priorities and support continuous improvement by providers;
  c. Policymakers, regulators, accreditors to consistently and reliably identify emerging and persistent trends in safety affecting diverse populations; and
  d. Members of the public to reduce the risk of harm in their own or family members' care and to contribute to safety improvement more generally.
- All state measure sets adhere to the Principles for Measuring Safety.
- All provider organizations understand and comply with state and federal reporting requirements for health care safety

Where do we go next

- BLC will begin publishing an annual report on safety in 2023
- A future advisory group will continue to develop the self-assessment and final list of core measures
- In collaboration with EOHHS, the BLC will convene a group of statewide stakeholders to talk about data harmonization
- We can also include language on how these items will build on existing efforts (NAP) like those listed below.

Tools and resources

Members of the task force identified some tools and resources that can be used or adapted by individual organizations for many of the recommendations in this report. The Betsy Lehman Center will continue to collect and curate these materials.

Below is a sample inventory of tools and resources identified by Task Force members.

	Resources	*Organizations*
Measures and measure sets	Multiple settings	AHRQ
	Multiple settings	Centers for Medicare and Medicaid Services
	Multiple settings	Joint Commission
	Hospitals and ASCs	Leapfrog
	Multiple settings	NQF
	Consumer experience	MHQP
	Ambulatory care providers	NCQA's Patient Centered Medical Home Program (PCMH)
Measurement recommendations and principles	Hospital Quality Star Rating Summit Recommendations	NQF
	Salzburg Principles for Measuring Patient Safety	IHI
Assessment tools and data dashboards	A Proposed Quality Report Card for Boards	Press Ganey
	Health Workforce Diversity Tracker	George Washington University
	Multiple tools and dashboards	AHRQ
	State Health System Performance Scorecard	The Commonwealth Fund
	Physician Practice Patient Safety Assessment Tool	Institute for Safe Medication Practices
	Medication Assessment	Quality Innovation Network- Quality Improvement Organizations
	Hospital Survey	Leapfrog

Acknowledgements

The Measurement and Transparency Task Force was appointed by the Massachusetts Health Care Safety and Quality Consortium in the spring of 2022. In the ensuing 18 months, more than two dozen individuals contributed their time and considerable talents to the task force.

The Massachusetts Health Care Safety and Quality Consortium and the Betsy Lehman Center for Patient Safety are grateful to the following individuals who contributed their time and expertise to the work of the Measurement and Transparency Task Force:

- Teresa Anderson, PhD, MSW, Massachusetts Department of Mental Health
- Ivyruth Andreica, PharmD, BSN, FISMP (*Co-Chair*), Medication Safety Consultant
- David Bates, MD, MSc (*Co-Chair*), Mass General Brigham, Brigham and Women's Hospital, Harvard Medical School
- Akriti Bhambi, M.Ed, formerly Massachusetts Health and Hospital Association

- Maryanne Bombaugh, MD, MSc, MBA, CPE, FACOG, Massachusetts Medical Society, Cape Cod Community Health Center
- Ray Campbell, JD, MPA, Center for Health Information and Analysis
- Isaac Chua, MD, MPH, Harvard Medical School, Brigham and Women's Hospital, Dana Farber Cancer Institute
- Sonali Desai, MD, MPH, Brigham and Women's Hospital
- Patricia Folcarelli, RN, MA, PhD, CRICO
- Paula Griswold, MS, Massachusetts Coalition for the Prevention of Medical Errors
- Robert Haffey, MBA, MSN, Signature Healthcare
- Robert Hanscom, JD, Coverys
- Paul Hattis, MD, JD, MPH, Lown Institute
- Emily Herman, Patient Experience Representative
- Josh Hyatt, DHS, MBE, MHL, DFASHRM, CPHRM, HEC-C, CPPS, Coverys
- Amina Khan, PhD, Center for Health Information and Analysis
- Benjamin Kruskal, MD, PhD, FAAP, FIDSA, Blue Cross Blue Shield of Massachusetts, formerly Tufts Medicine Integrated Network
- Elizabeth Leahy, Esq., Massachusetts Association of Health Plans
- Patricia McGaffigan, MS, RN, CPPS, Institute for Healthcare Improvement
- Judith Melin, MA, MD, FACP, Massachusetts Medical Society, Beth Israel Lahey Health
- Elizabeth Mort, MD, MPH, Massachusetts General Hospital, Mass General Brigham, Harvard Medical School
- Christin Price, MD, Perinatal-Neonatal Quality Improvement Network of Massachusetts (PNQIN)
- Barbara Proffitt, RN, BHA, Massachusetts League of Community Health Centers
- Barbra Rabson, MPH (*Co-Chair*), Massachusetts Health Quality Partners
- Eric Reines, MD, FACP, Element Care PACE
- Frank Robinson, PhD, Baystate Health
- Matthew Salmon, PT, MHP, MBA, SALMON Health and Retirement
- Luke Sato, MD, CRICO
- Mark Schlesinger, PhD, Yale School of Public Health
- Michael Stanek, Health Policy Commission
- Lakshman Swamy, MD, MBA, MassHealth
- Susan Todd, MEd, Patient Experience Representative
- Huong Trieu, PhD, Center for Health Information and Analysis
- Sandra Wolitzky, JD, Massachusetts Attorney General's Office
- Wei Ying, MS, MBA, Blue Cross Blue Shield of Massachusetts

Endnotes

[1] Panagioti M, Khan K, Keers RN, et al. Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis. *BMJ.* 2019;366:l4185. doi:10.1136/bmj.l4185

[2] National Patient Safety Foundation's Lucian Leape Institute. *Shining a light: Safer health care through transparency*. Published 2015. Accessed April 20, 2023. https://www.ihi.org/resources/Pages/Publications/Shining-a-Light-Safer-Health-Care-Through-Transparency.aspx

[3] Office of Inspector General. *Few Adverse Events in Hospitals Were Reported to State Adverse Event Reporting Systems*. U.S. Department of Health and Human Services. Published July 19, 2012. OEI-06-09-00092. Accessed April 10, 2023. https://oig.hhs.gov/oei/reports/oei-06-09-00092.pdf

[4] Rao P, Fischer SH, Vaiana ME, Taylor EA. Barriers to Price and Quality Transparency in Health Care Markets. *Rand Health Q*. 2022;9(3):1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9242565/

[5] Deshpande JK, Green A, Schellhase DE. Measuring what really matters in patient safety. *Curr Treat Options Peds.* 2015;1:286-297. doi:10.1007/s40746-015-0036-2

[6] Weintraub WS, Garratt KN. Challenges in Risk Adjustment for Hospital and Provider Outcomes Assessment. *Circulation*. 2017;135(4):317-319. doi:10.1161/CIRCULATIONAHA.116.025653