Many contemporary management approaches call for an increase in transparency in the activities of management and staff. This is a dramatic shift from the days when the carrot-and-stick approach to management was an executive’s most reliable tool to move an organization forward. But how much transparency is needed, and at what point can such transparency compromise the organization in terms of its competitive position—or its liability exposure? How will efforts in transparency be rewarded for the healthcare executive who has the courage to become the champion for change? The numerous issues that come to bear on this matter call for leaders to approach transparency with caution, diligence, and, ultimately, compassion.

Embracing transparency enables an organization to conform to market expectations while satisfying the demands of regulators. However, there’s a better reason to make this commitment. The single greatest argument for increased transparency is that it reveals improvement opportunities in the organization. If hospital executives don’t identify these opportunities, they risk a false sense of security and a blind spot to emerging threats. An organization that fully embraces transparency can undertake the important work of performance improvement—not only doing things right, but doing the right things. Calls for transparency are not limited to the healthcare industry; Federal Reserve Chairman Ben Bernanke conducted the first press conference in the bank’s history on April 27 of this year.

Unfortunately, many healthcare cultures aren’t prepared for a shift to transparency. Transparency exposes both good and poor performance, and employees who fear punishment will not readily heed the call for increased reporting of performance measures. Moreover, employees will be reluctant to expose their peers if it leads to scrutiny of performance. How do healthcare executives overcome these barriers?

A PROTOCOL FOR TRANSPARENCY
The journey to transparency begins with leaders recognizing, and subsequently convincing the staff, that it’s about the process, not the people. Management must begin with the premise that staff do not intentionally produce poor results. Reckless staff are easy to find and dismiss; performance of others will be limited, in varying amounts, by the design of the system in which they work and by their own physical limitations. Only when system design flaws are identified can management repair them, and only when human errors are discovered can management assist people to cope with, correct, and avoid errors in the future. To make these discoveries and to
understand what to fix, management must leverage the knowledge of staff closest to the work and the process.

One might be tempted to dismiss this advice as a case of “easier said than done.” However, many organizations find that transparency is aided by adopting a just culture. The term just culture, coined by British scholar James Reason, refers to a culture that embodies these assumptions and conditions:

- Management is responsible for providing the systems and structures for employees to accomplish their work.
- Management and employees come to the work environment with different values and expectations. Managers expect employees to perform, and employees reasonably expect systems to support their performance.
- Employees are presumed to be well-intentioned, but they may occasionally drift from standards of practice. When errors are discovered, they can be categorized as human error, at-risk behavior, or reckless behavior.
- Human error and at-risk behavior often provide important clues to system improvement opportunities. When people feel safe to report findings that reveal these improvement opportunities, the organization can quickly solve problems, prevent recurrence, and boost performance.

A properly implemented just culture program will require managers and staff to openly discuss the discovery of any breach of duty (Frankel, Leonard, and Denham 2006). An algorithm that addresses the following questions is applied to the situation being examined:

- Did the employee intend to cause harm?
- Did the employee knowingly and unreasonably increase risk?
- Would another similarly trained and skilled employee in the same situation act in a similar manner?
- Did the social benefit sought by the employee legitimately outweigh the attendant risks?

Although the inquiry clearly focuses on the employee’s behavior, a just culture takes great care to reveal the system’s own contribution to the error. Inevitably, the process of inquiry works when the parties reach a better understanding of both individual and system requirements for improvement. All parties win when a process such as just culture replaces arbitrary forms of reward or punishment.

KP ONCALL’S JOURNEY TO A JUST CULTURE

“The practice of just culture principles creates a greater sense of accountability among all company employees,” notes Melissa Bonwit (2011), director of quality and training at KP OnCall. Our organization, a subsidiary of Kaiser Permanente, has pioneered the application of these principles in a contact center environment.
Bonwit continues, “This sense of accountability ultimately translates into a more just and manageable corporate culture that proactively deals with, rather than reacts to, human behaviors.” When the focus is on the process and not the people, management intervention can include anything from simple error-proofing to more complex solution sets such as Lean or Six Sigma.

Bonwit recalls the days when staff were wary of management’s intentions and generally considered the organization’s oversight of employee performance to be oppressive and arbitrary. Since the implementation of the just culture program at KP OnCall, employee satisfaction scores have risen 30 percent (however, because the company is constantly evolving, this may have been a result of many other factors). KP OnCall management, recognizing that such a culture change initiative can take several years to gain momentum, has committed to an annual deployment plan for the just culture program, including interactive learning opportunities, awareness exercises and drills, custom-made videos demonstrating how to recognize at-risk behavior, and opportunities for open debate.

“Our challenge is to remind implementing staff that they are at the heart of the just culture behavior management principles and must adopt and consistently model its duties and behaviors,” Bonwit says. “The changes are slow, and often just culture champions need to paddle back a little in order to move forward. It’s a slow process that forces us to reverse a culture that historically might shoot first and ask questions later.”

TRANSPARENCY IS PERFECTLY CLEAR

Establishing the return on investment from transparency and just culture may be difficult, as much of their benefit is in the avoidance of risks with uncertain probabilities. The practice of enterprise risk management (ERM) is increasingly found in larger health systems as a means to quantify a portfolio of risk, recognizing that positive and negative risks can legitimately offset each other so long as the portfolio as a whole generates positive returns. Readers familiar with an FMEA (failure modes and effects analysis) can imagine how ERM might work—the FMEA is used to create a fully transparent view of process performance on a more narrow scale, while the ERM provides for a similar analysis organization-wide.

When a hospital in the Midwest decided to build a new culture of safety, one approach was to introduce the option of anonymous reporting of errors and near misses. Then–chief operating officer Barbara Knutzen, FACHE, was stunned to find the rate of reported medication errors skyrocket over 100 percent on a control chart just days later (see Exhibit 1). “Anyone looking at this chart who did not know any better would have thought that we simply fell apart in the quality of our processes,” recalls Knutzen (2011). “But we were thrilled to see the results when we put it in the proper context. People felt compelled to report concerns when the fear of punishment was removed. Finally we had proof of what we suspected all along: that there were many more error and process issues than reported. We could then actually begin the work of improving things.”
Apart from the tangible performance improvement benefits it can bring, transparency has a tangible and positive impact on an organization’s culture. In 1999, Charleston Area Medical Center (CAMC), in tandem with their launch of an ambitious Six Sigma deployment, began a self-assessment of the organization’s capability to articulate a vision of excellence for the organization, mobilize commitment to the vision, and sustain change. A survey asked staff to assess these and other capabilities on a Likert scale. CAMC repeated the process each year as the principles of self-examination and improvement continued to spread throughout the organization. Then, they charted the results (see Exhibit 2).
“While we expected tangible returns from our investment in a Six Sigma program, we were surprised to see how well our drive to be honest with ourselves about where improvement was needed would have such a positive effect on the entire culture of the organization,” says Glenn Crotty, MD, CAMC’s chief operating officer (2011).

THE INSIDE TRACK
Leaders might find that increased transparency reveals things about their organizations that they didn’t necessarily want to know. Some findings can be alarming, and it’s best for the organization to be prepared to devote serious attention to the process and what its outcomes suggest about the quality of care practiced within its walls.

In his song “On the Road to Find Out,” Cat Stevens laments the fact there is “so much left to know,” but realizes that “the answer lies within.” Transparent organizations reap tangible rewards because they have the courage to look within and the resolve to do something with what they discover. Transparency will become the new normal in healthcare operations, and leaders would be wise to get the process started.

REFERENCES
Crotty, G. 2011. Interview with author, April 29.
Knutzen, B. 2011. Interview with author, April 2.

For more information on the concepts in this column, please contact Mr. Lazarus at ian.r.lazarus@kp.org.