that Congress will restore DSH to its previous level. And even such a restoration would not solve the underlying structural problem of poor targeting by states. Moreover, reopening DSH for debate could result in even bigger cuts.

The second option is to create even clearer incentives for states to target their remaining DSH funds. CMS could retain the current framework for allocating states' shares but set a higher bar for identifying DSH providers, on the basis of the overall profile of a state's hospitals, not just the hospitals currently receiving DSH funds. This approach would provide incentives to states that don't target their DSH allocation to do so, without penalizing those already doing a good job.

The third option is to recognize that the Medicaid DSH program has largely become a federal program, with few state dollars supporting it.[1] Since the federal government is paying the tab, Congress could adopt a straight-forward, national formula for determining hospital eligibility and DSH payment amounts. Support would thus be directed to safety-net facilities that serve important national health security interests, such as operating full-service emergency departments, participating in their state's trauma care system, and anchoring their region's disaster plan.[1]

If properly enforced, the proposed rule will help sustain the safety net. But if the state governments that refused to expand Medicaid also refuse to rethink their approach to allocating DSH funds, there will be little money left to sustain their safety-net hospitals when the cuts deepen in 2017. The cascade of service reductions and facility closures that this could trigger would have sweeping consequences. Safeguarding the safety net in such politically perilous times will require creative rulemaking by CMS. The proposed DSH rule is a good start, but much remains to be done.

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Improving Patient Safety through Transparency

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Transparency — especially when things go wrong — is increasingly considered necessary to improving the quality of health care. By being candid with both patients and clinicians, health care organizations can promote their leaders' accountability for safer systems, better engage clinicians in improvement efforts, and engender greater patient trust. Today, many institutions have initiated efforts to improve the sharing of information on publicly reported performance measures, but transparency re-

garding medical errors has proved much more difficult to achieve.

U.S. health care organizations still have a ways to go to achieve a culture in which all errors are openly identified and investigated. Ideally, the primary goal of these investigations is not punitive, but rather to understand what happened and facilitate open discussion in order to prevent similar mistakes from happening again. National surveys on the patient-safety culture of medical offices and hospitals consistently reveal substantial room for im-

provement in achieving these aims.[1] Last year, less than two thirds of staff members reported having a favorable perception of their hospital's openness in communication, and less than half reported that their hospitals respond to errors in a non-punitive way.

Fortunately, there are some bright spots that demonstrate progress toward greater openness. For example, we have seen steady growth in the number of safety reports filed by clinicians now that institutions routinely

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encourage such filings. Another prominent development has been the adoption of disclosure, apology, and offer (DA&O) programs. Taking a principled approach to addressing errors, organizations instituting these programs commit to fully investigating adverse events and implementing interventions to prevent their recurrence. They also openly admit their errors to patients (and make offers of compensation, when appropriate), letting the chips fall where they may when it comes to reputation and liability.

Contrary to many predictions that DA&O programs could result in the proliferation of legal claims and costs, data from two pioneering programs have revealed improved liability outcomes, including a 60% decrease in legal and compensation costs in one program.[2] Proponents of DA&O programs also tout downstream safety benefits from greater transparency. Early program successes have fueled extensive interest and a push for broader implementation, but there has not been immediate widespread adoption, so transparency is far from ubiquitous.

Long-standing barriers have slowed progress on this front. Institutions and clinicians continue to worry about the reputational and financial risk they assume when they admit to errors. An institution may fear that as the public hears more about its gaps in safety, its reputation and ranking — as well as patient volumes and revenue — may decline. Because the empirical data on DA&O programs are limited, organizational leaders may still worry that disclosure will also raise liability costs. As a result, if a patient is not aware of an

error, the incentives to keep quiet can be very powerful. I'm hopeful, however, that the ethical imperative to proactively disclose errors, coupled with the growing evidence base on the associated liability and safety benefits, will continue to move our leaders toward greater transparency.

Health care organizations that aim to be transparent about error may take a number of steps to support and engage their clinicians in this endeavor. First, institutions may attempt to allay clinicians' fears over losing their jobs because of a human error. Embracing a "just culture" in which there is balanced accountability can help accomplish this aim[3]: balancing accountability means that clinicians do not face blame or repercussions for human errors (e.g., a simple error in execution) but are held accountable for reckless or intentional transgressions (e.g., a willful violation of a protocol).

Even if an institution chooses to address human errors by implementing better systems rather than by punishing its employees, effectively communicating this strategy to staff remains challenging, especially when it comes to cognitive errors made by a single individual. For example, many safety experts would say that even a simple human error in test interpretation merits a systems fix and not punishment for the clinician. Nevertheless, many clinicians may still see this kind of event primarily as an individual's, rather than a systems, failure — and therefore may be disinclined to report or discuss such events. Health care organizations may foster greater openness from their staff by ensuring that simple human errors

will not lead to punishment and also that their clinicians understand that.

On the other end of the spectrum, reckless or willful violations that can lead to disciplinary action also pose a communication challenge. Because organizations tend to be reticent about discussing why corrective actions were taken against an employee involved in reckless or intentional wrongdoing, clinicians may incorrectly believe that the employee was punished for a systems error. This risk further reinforces the importance of disseminating information about what actually went wrong in all cases of error: only then may employees appreciate their institution's implementation of balanced accountability.

Second, patients' and providers' emotional and reputation-related concerns require sensitivity. Even if a case is treated and discussed as a systems failing, the clinicians involved may still feel accountable and readily identifiable. Similarly, patients and family members may want to put the event behind them but feel unable to do so if information about it is being disseminated. Consequently, organizations may benefit from involving patients and clinicians in the communication process and addressing their concerns before releasing information. Without these steps, transparency efforts may backfire if clinicians start to avoid discussion for fear of feeling exposed or if patients and families are further upset.

Third, organizations may attempt to reduce clinicians' concerns over liability-related reporting requirements. Under current law, when systems-level errors result in payments to patients or

families, physicians may still be reported to state boards as well as the National Practitioner Data Bank (NPDB) and may feel unfairly singled out. In addition, clinicians may worry about payments being made in cases in which no error occurred,[4] which further reduces the incentives to be open. Institutions can avoid triggering physician-reporting requirements by accepting sole liability for systems errors. However, that tack is somewhat controversial, because the NPDB is designed to help track all valid claims against physicians.

To address liability-related concerns, there are some potential legal reforms through which individuals would still be held accountable for reckless or intentional behavior, but not for human or systems errors. Options include changing NPDB and state-board requirements so that systems errors do not have to be reported against individuals. Another option is to enact "enterprise liability" legislation that allows or requires institutions to take sole fiscal and reporting responsibility for systems errors. A third is implementing a system of administrative health courts in which compensation for a claim does not result in the reporting of a clinician; under such a system, disciplinary investigations would have to be filed and investigated separately. Not only would such reforms better align liability with modern safety principles; they could also cultivate greater openness in clinicians. Experience in other countries shows that clinicians in such systems frequently advocate for patient compensation. And by removing clinicians' concerns from settlement discussions, organizations may also find themselves better positioned to resolve claims more quickly.

U.S. health care institutions have begun promoting transparency to improve the safety of care. Their success will require a collective understanding of the importance of transparency as well as a strong commitment to openness. Institutions are today better positioned to foster a culture that balances accountability and addresses the emotional and legal concerns of patients and clinicians. Liability reforms can also help to better align incentives to facilitate transparency. Ultimately, no matter how daunting the task, shining a light on our errors shows the path to improvement.

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