Flipping the Iceberg: Seeing, Understanding, and Managing Risk – An Evidence-Producing Standard

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K. Scott Griffith, President and Managing Partner
Dale Oda, MD, BSEE, Partner and Healthcare Advisor
SG Collaborative Solutions, LLC

KANSAS MEDICAL SOCIETY
Established 1859

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Flipping the Iceberg:

Collaborative Just Culture® Program

(Seeing, Understanding, and Managing Risk with an Evidence-Producing Standard)

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Gddn Rgd /MD, BSEE / Sdwqhudqg Khdowfduh Dgylvru

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Statewide Cohort Adoption

KHC, in partnership with state organizations, is facilitating a series of cohort hospitals to train and achieve CJCP qualification, beginning in 2025. The data and evidence gathered from this pilot will provide guidance for a larger roll-out across Kansas and ultimately become the standard used in hospitals across the state.

KHC is confident that this investment will lead to measurable improvements in patient safety metrics, reduce costly medical errors, result in fewer claims, and create a paradigm shift in achieving high reliability in healthcare; setting a precedent for nationwide adoption.
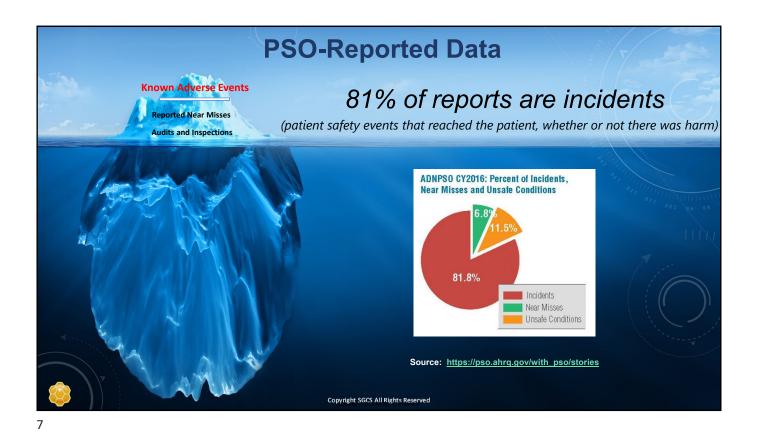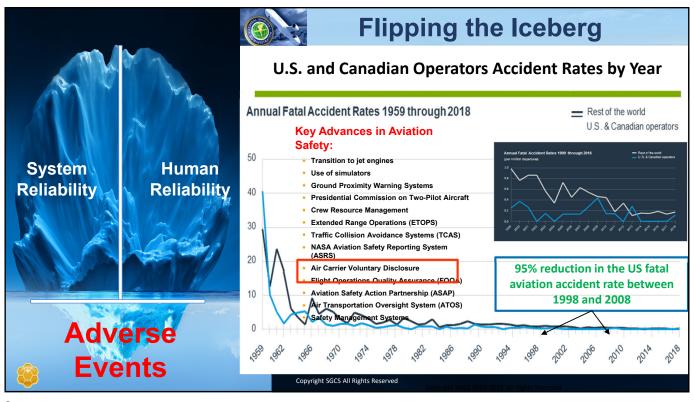
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Slide 7: PSO-Reported Data
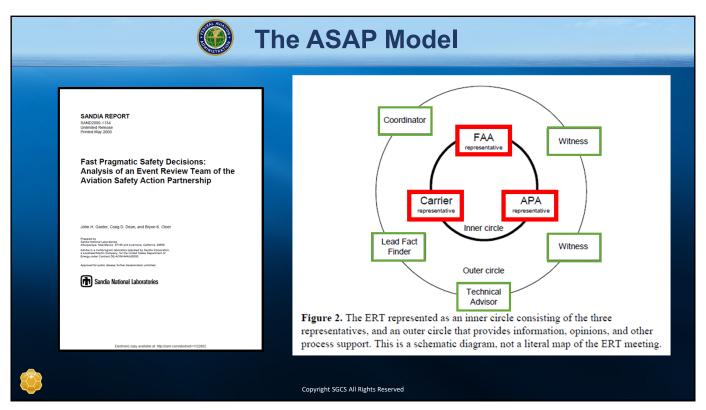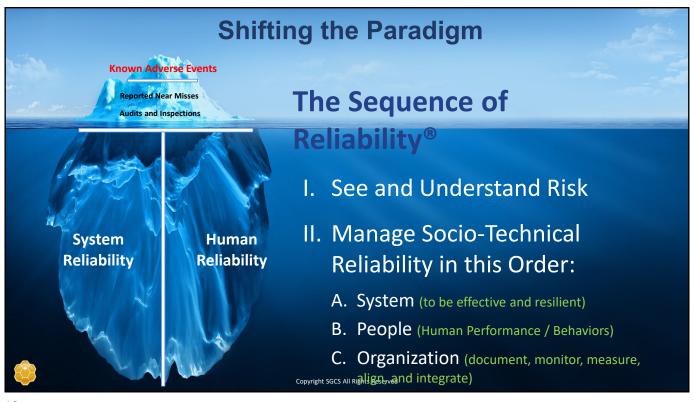
Known Adverse Events
Reported Near Misses
Audits and Inspections

81% of reports are incidents
(patient safety events that reached the patient, whether or not there was harm)

ADNPSO CY2016: Percent of Incidents, Near Misses and Unsafe Conditions

6.8%
11.5%
81.8%

Incidents
Near Misses
Unsafe Conditions

Source: https://pso.ahrq.gov/with_pso/stories

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Slide 8: Flipping the Iceberg

System Reliability — Human Reliability

Adverse Events

U.S. and Canadian Operators Accident Rates by Year

Annual Fatal Accident Rates 1959 through 2018

Rest of the world
U.S. & Canadian operators

Key Advances in Aviation Safety:
- Transition to jet engines
- Use of simulators
- Ground Proximity Warning Systems
- Presidential Commission on Two-Pilot Aircraft
- Crew Resource Management
- Extended Range Operations (ETOPS)
- Traffic Collision Avoidance Systems (TCAS)
- NASA Aviation Safety Reporting System (ASRS)
- Air Carrier Voluntary Disclosure
- Flight Operations Quality Assurance (FOQA)
- Aviation Safety Action Partnership (ASAP)
- Air Transportation Oversight System (ATOS)
- Safety Management Systems

Annual Fatal Accident Rates 1999 through 2018

95% reduction in the US fatal aviation accident rate between 1998 and 2008

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The ASAP Model

SANDIA REPORT
SAND2000-1134
Unlimited Release
Printed May 2000

Fast Pragmatic Safety Decisions:
Analysis of an Event Review Team of the
Aviation Safety Action Partnership

John H. Ganter, Craig D. Dean, and Bryon K. Cloer

Figure 2. The ERT represented as an inner circle consisting of the three representatives, and an outer circle that provides information, opinions, and other process support. This is a schematic diagram, not a literal map of the ERT meeting.

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Shifting the Paradigm

Known Adverse Events
Reported Near Misses
Audits and Inspections

System Reliability

Human Reliability

The Sequence of Reliability®

I. See and Understand Risk

II. Manage Socio-Technical Reliability in this Order:

A. System (to be effective and resilient)

B. People (Human Performance / Behaviors)

C. Organization (document, monitor, measure, align, and integrate)

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History of Just Culture

- In 1997, Professor James Reason first coined the term "just culture" in his book, *Managing the Risk of Organizational Accidents*

- The just culture philosophy became an algorithm focused on employee behavior

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A Bias toward Behavior

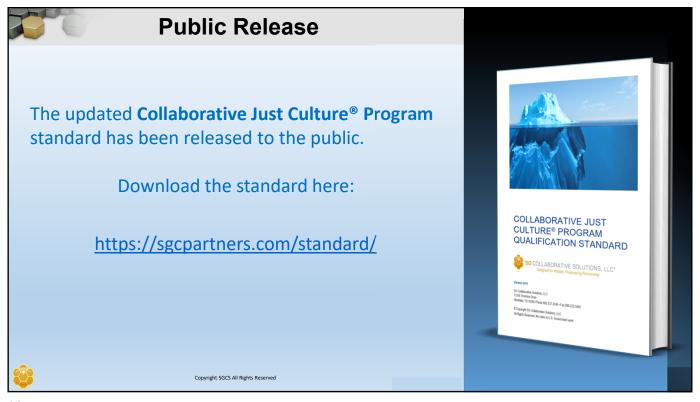

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An Aspirational Approach

Just culture in healthcare: An integrative review

Nina P Barkell [1], Susan Stockton Snyder [1]

Affiliations + expand

PMID: 33231884   DOI: 10.1111/nuf.12525

[Full text links]   [66 Cite]

Abstract

Background: In spite of two decades of the patient safety movement in the United States, healthcare safety remains a significant problem. The paucity of empirical literature related to Just Culture in healthcare indicates a need for this concept to be examined and operationalized.

Source: Barkell NP, Snyder SS. Just culture in healthcare: An integrative review. Nurs Forum. 2021 Jan;56(1):103-111. doi: 10.1111/nuf.12525. Epub 2020 Nov 24. PMID: 33231884.

For decades, no standards or definitions of just culture existed.

It has remained aspirational, without being evidence-based.

Until now…

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Public Release

The updated **Collaborative Just Culture® Program** standard has been released to the public.

Download the standard here:

https://sgcpartners.com/standard/

COLLABORATIVE JUST CULTURE® PROGRAM QUALIFICATION STANDARD

SG COLLABORATIVE SOLUTIONS, LLC®
Designed for Impact. Powered by Partnership.

Version 24-0

SG Collaborative Solutions, LLC
13310 Thornton Drive
Westlake, TX 76262 Phone 682-237-2340 • Fax 888-223-5405

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Collaborative Just Culture® Program

A program to help achieve high reliability through workplace justice and collaboration

- The world's first just culture standard

- Evidence-producing ➡ evidence-based standard

- Documented, monitored, and measured

- Independently audited by a third-party

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The Ascent to CHRO

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Required Elements of a CJC Program

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Alignment of Key Processes

Collaborative Risk Review

- **Risk Analysis in Context**
- Diverse Perspectives
- Identify Risk Contributors
- Standardized Methods/Tools and Taxonomy
- Documented Findings, Recommendations, and Follow-up

Triad Review

- **Manage Significant Risks e.g. Potential Employee Discipline**
- Checks and Balance
  - Operational Expectations (Mgt)
  - Workplace Fairness (HR)
  - Reliability (S/Q/R)
- Avoids Bias, Over/Under-reaction

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Sequenced Integration of CJCP

Phase 1: Development	Phase 2: Education	Phase 3: Qualification
Goal: Develop Aligned Elements	**Goal: Train the Workforce**	**Goal: Operationalize & Sustain CJCP**

• Executive Engagement
• Labor Involvement (if applicable)
• Policy Alignment
• RMT Selection
• Training (Proficiency) and Role Qualifications
  • RMT, HR, Safety/Quality Risk
	• Operational Ability:
	  • Executives
	  • Departmental Directors
	  • Managers & Supervisors
	• Introduction for Non-Supervisory Staff
	  • Employees
	  • Contractors
		• Risk Reporting System
		• Collaborative Risk Review Process
		• Triad Review Process
		• Sustainment Plan
		• Program Qualification
		  • Independent Audit

Key Benefit: Set Program Expectations	**Key Benefit: Re-Align Culture**	**Key Benefit: See, Understand, & Manage Risk**

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Independent Biennial Audits

Initial Audit

- Examines the program infrastructure
  (Commitment, RMT, policies, training, tools, sustainment & measurement plan)

Requalification Audits (every 2 years)

- Examine the organization's documenting, monitoring, and measuring

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CJC.7 Sustainment Plan and Internal Evaluation

- **Sustainment Plan:** CJCP sustainment plan must be documented

- **Internal Evaluation:** Specific process for conducting ongoing measurements, an annual internal evaluation and reporting the results

- **Periodic Review Meetings** with Executive Leadership

- **Annual Reports** to the Governing Body

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1 Fair and Consistent Treatment of Employees

Assess Evidence-based Processes and Tools to Evaluate Employees (fairly and consistently)

Process Evaluated	Documentation	Source
Triad Review Process • Termination of Employment • Other Disciplinary Actions	Case Reviews	Human Resources
Management of Performance vs. Behavior	Performance Improvement Plans Behavioral Coaching and Counseling	All Departments

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2 Collaborative Management of Risk

Assess *how* the organization sees, understands, and manages risk, including responses to all findings and recommendations

Process Evaluated	Documentation	Source
Fact-Gathering	Systems examined, interviews, timing	Human Resources Safety, Quality, Risk Performance Improvement
Collaborative Risk Reviews	Taxonomy, Findings, Recommendations, Timing	Safety, Quality, Risk
Triad Reviews	Taxonomy, Findings, Recommendations	Human Resources Safety, Quality, Risk Performance Improvement
Risk Reporting (vs. Event Reporting)	Ratio of Risks to Events reported, Ratio of Reporting by Departments, Roles	Safety, Quality, Risk All Departments

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3 Perception of Culture Survey

Assess the perception of the organizational culture and workplace justice through a survey of different work groups.

Work Group Perspectives to Obtain
Senior Executives, Vice-Presidents
Directors, Managers, Supervisors
Frontline Staff
Quality, Safety, Risk, Performance Improvement Departments

- Survey should be confidential and voluntary but include a representative sampling from each department.
- Survey questions should be reviewed by the Reliability Management Team
- Results should be documented by department.

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Kansas Cohort Adoption

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Kansas Cohort Adoption

Expected Average Price per Hospital before Stipends:

$25,000* (*exact price scaled to number of employees)

Expected External Funding Incentives:

- Stipend to participate
- Premium reduction once qualified
- Progressive discounts based on claims reduction

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Reasons Organizations Adopt the Standard

- Achieve reliability across all organizational attributes
- Prevent failures and adverse events – reducing claims and lowering awards
- Optimize assets and resources
- Improve morale and cultural cohesiveness
- Reduce burnout and raise retention
- Gain competitive advantages
- Insurance premium reductions
- Ensure long-term sustainability
- "It's the Right Thing to Do"

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Healthcare Incentives

These standards meet and exceed the proposed CMS Patient Safety
Structural measures (PSSM), intended to assess whether
hospitals demonstrate a *structure, culture, and leadership commitment that
prioritizes safety*:

- Leadership commitment to eliminating preventable harm;
- Strategic planning and organizational policy;
- Culture of safety and learning health systems;
- Accountability and transparency; and
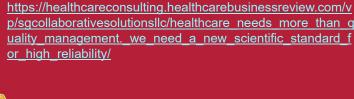- Patient and family engagement.

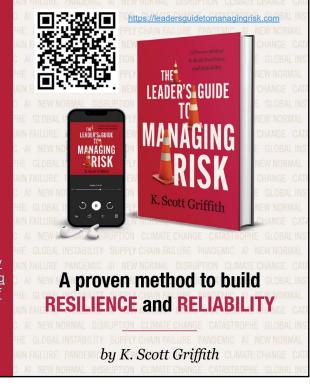29

Recent Articles

By K. Scott Griffith

- **Chief Healthcare Executive:**

  https://www.chiefhealthcareexecutive.com/view/we-need-a-new-scientific-standard-for-high-reliability-viewpoint

- **Healthcare Business Review:**

  https://healthcareconsulting.healthcarebusinessreview.com/vp/sgcollaborativesolutionsllc/healthcare_needs_more_than_quality_management._we_need_a_new_scientific_standard_for_high_reliability/

https://leadersguidetomanagingrisk.com

A Proven Method to Build Resilience and Reliability

THE LEADER'S GUIDE TO MANAGING RISK

K. Scott Griffith

**A proven method to build
RESILIENCE and RELIABILITY**

by K. Scott Griffith

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About Us

SG Collaborative Solutions, LLC™
Designed for Impact. Powered by Partnership.

We are an enterprise risk management firm specializing in reliable performance in high-consequence industries and organizations. We are the authors of the Collaborative High Reliability® and Collaborative Just Culture® standards of proficiency-based, socio-technical improvement.

Join us at:
https://sgcpartners.com/

Scott's email:
scott@sgcpartners.com

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Next Steps

- KHC is actively applying for grant funds
- Organizations ready to move forward may pay to participate in the program
  - SG Solutions cost listed in previous slide
  - KHC TA cost TBD
- Participation onboarding will include:
  - Contract with SG Solutions
  - Memorandum of Understanding(MOU) with KHC

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Next Steps Continued

- First Cohort scheduled to start January 15, 2025
  - Space is limited to 15 organizations
  - If interested in participating in the first cohort email us at: info@khconline.org

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Questions?

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Upcoming Education and Important Dates

- **11/5 Flipping the Iceberg: Seeing, Understanding, and Managing Risk – An Evidence-Producing Standard**
- **11/7 Navigating Rural Health - Mobile Health**
- **11/7 Physician Forum: How AI at Work Will Advance Human Intelligence**
- **11/8 MBQIP Basics Training**
- **11/12 Health Care Preceptor Academy**
- **11/12 Financial Webinar - Does Your Charity Care Policy Need a Refresh?**
- **11/21 KHA Rural Health Symposium, Wichita**
- **12/2 Last day to register for MIPS Value Pathway (MVP) for PY 2024**
- **Dec 2024 - Final MIPS Eligibility will be provided by CMS for PY 2024**
- **12/31 Last day to apply for Promoting Interoperability (PI) Exceptions**

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→ *Find contact info and more at:*
www.KHConline.org/staff

Malea Hartvickson
Executive Director

Mandy Johnson
Senior Director, Programs

Treva Borcher
Director of Operations

Eric Cook-Wiens
Data & Measurement Director

Liz Warman
Quality Improvement Advisor

Jill Daughhetee
Director of Education and Communications

Azucena Gonzalez
Health Care Quality Data Analyst

Erin McGuire
Quality Improvement Advisor

Jenni Peters
Quality Improvement Advisor

Julia Pyle
Quality Improvement Advisor

Patty Thomsen
Quality Improvement Advisor

Rebecca Wagner
Grants Coordinator

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