Collaborative Just Culture® Program Qualification Standard:

An Evidence-Producing Approach to Healthcare Reliability

Presented by: K. Scott Griffith, President and Managing Partner

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40th Annual Risk Managers' Meeting

IHA Illinois Health and Hospital Association

Roadmap to Collaborative High Reliability®

I. The Why

- Background and History
  - Evidence-Based and Evidence-Producing
- Rewards and Incentives
- The Need for a Standard

II. The What

- The Sequence of Reliability®: Seeing, Understanding, and Managing Risk
- The CJCP Standard

III. The How

- CJC Program Qualification
- CHR Organization Certification

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Failure to See & Understand Risk	System Failures	Human Failures	Organizational Failures

Inconsistent Treatment of Employees, Physicians & Patients

Inadequate Education/Experience

Sexual Harassment

Adverse Drug Events

Injuries

PPE shortages

Mistaken Laboratory Tests

Cyber Attacks

Restraint failures

Staffing shortages

Surgical Site Infections

Falls

RISK

Burn Out

Alarm Fatigue

Labor & Delivery Events

Omission errors

Lack of equipment

Infections

Mental Health Challenges

Blood Transfusion Errors

Privacy Breaches

Out-of-date polices

Delay in Diagnosis

Work Arounds

Wrong-Site Surgeries

Inappropriate Care

Inadequate Staff Training

Lack of evidenced based practice

Insulin Mis-Administration

Wound Care Breakdowns

Psychological Harm

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Shifting the Paradigm

Known Adverse Events

Reported Near Misses

Audits and Inspections

We will never achieve high reliability by investigating harmful events alone.

Socio-technical science has proven the more risks we identify and manage "below the surface" the better our chances of prevention…

…but we must document, monitor, and measure to achieve evidence-based success.

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Shifting the Paradigm

Known Adverse Events

Reported Near Misses

Audits and Inspections

We will never achieve high reliability by investigating harmful events alone.

We must see, understand, and manage risk daily.

It starts with frontline employees and physicians feeling safe to report.

We do this by committing to an evidence-based program.

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Evidence-Based vs Evidence-Producing

How an accident gave us the checklist, and safer flying

On October 30, 1935, a Boeing Model 299 (the forerunner to the B-17) crashed shortly after takeoff at Wright Field in Dayton, Ohio. An inquiry discovered no problem with the sophisticated aircraft's design. Rather, the report cited human error as the cause. The pilot had forgotten to release a safety lock.

What happened next would change aviation safety forever.

The Army Air Corps implemented the preflight checklist, a revolutionary new protocol that became the standard for the entire aviation industry.

This action was NOT evidence-based.

But it became evidence-producing.

Source: Smithsonian National Air & Space Museum,
Dave Kindy, *Air & Space Quarterly, December 21, 2022*

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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
- For decades, no standards or definitions existed
- Has not been evidence-based

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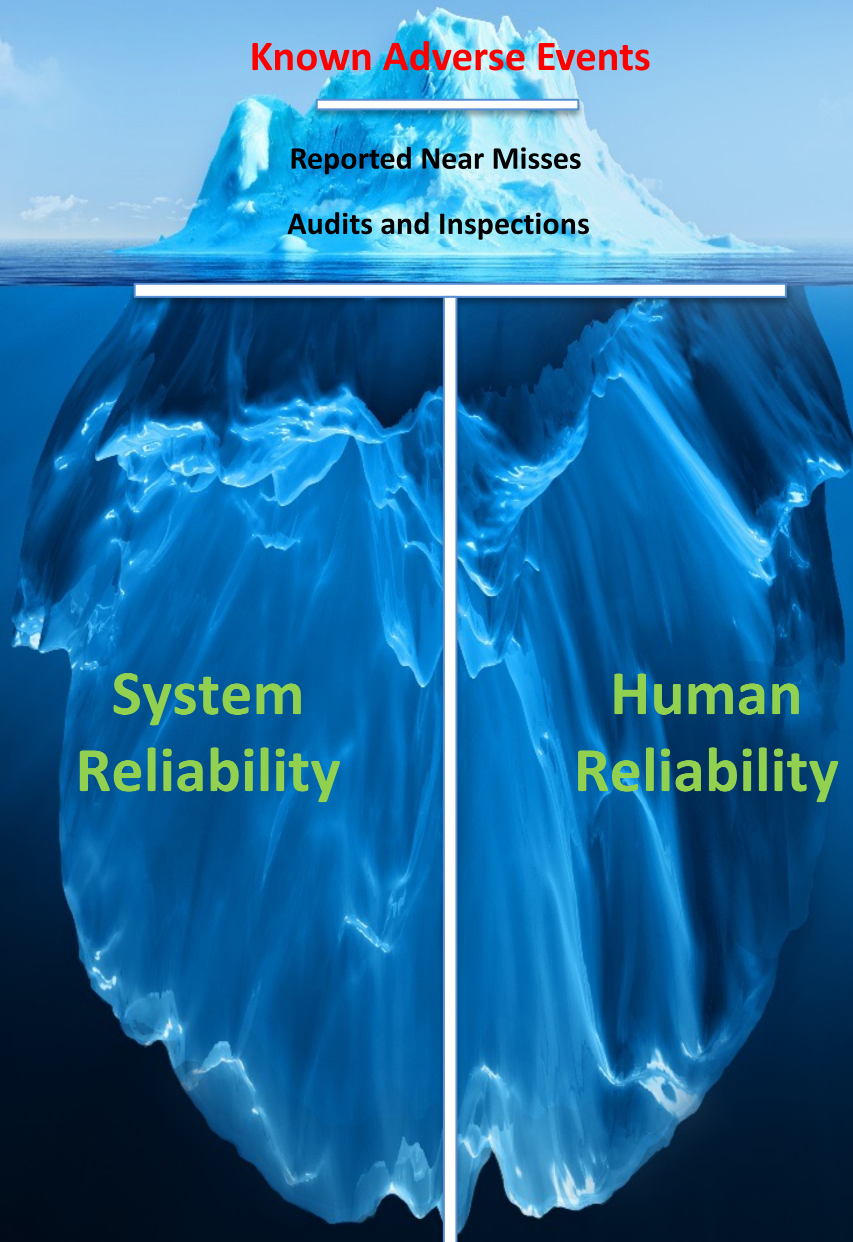
Shifting the Paradigm



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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Flipping the Iceberg

Adverse Events

System Reliability

Human Reliability

U.S. and Canadian Operators Accident Rates by Year

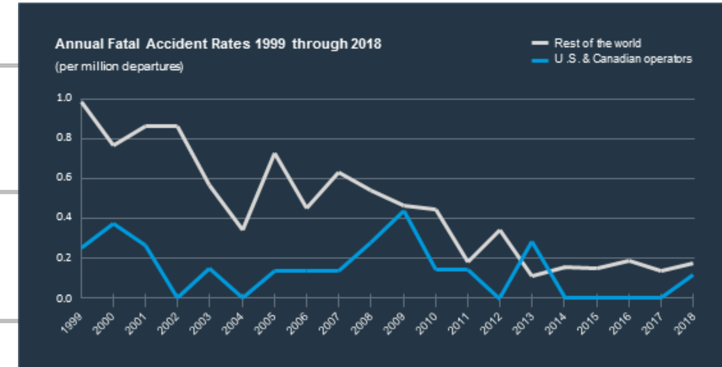
Annual Fatal Accident Rates 1959 through 2018

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

50
40
30
20
10
0
1959 1962 1966 1970 1974 1978 1982 1986 1990 1994 1998 2002 2006 2010 2014 2018



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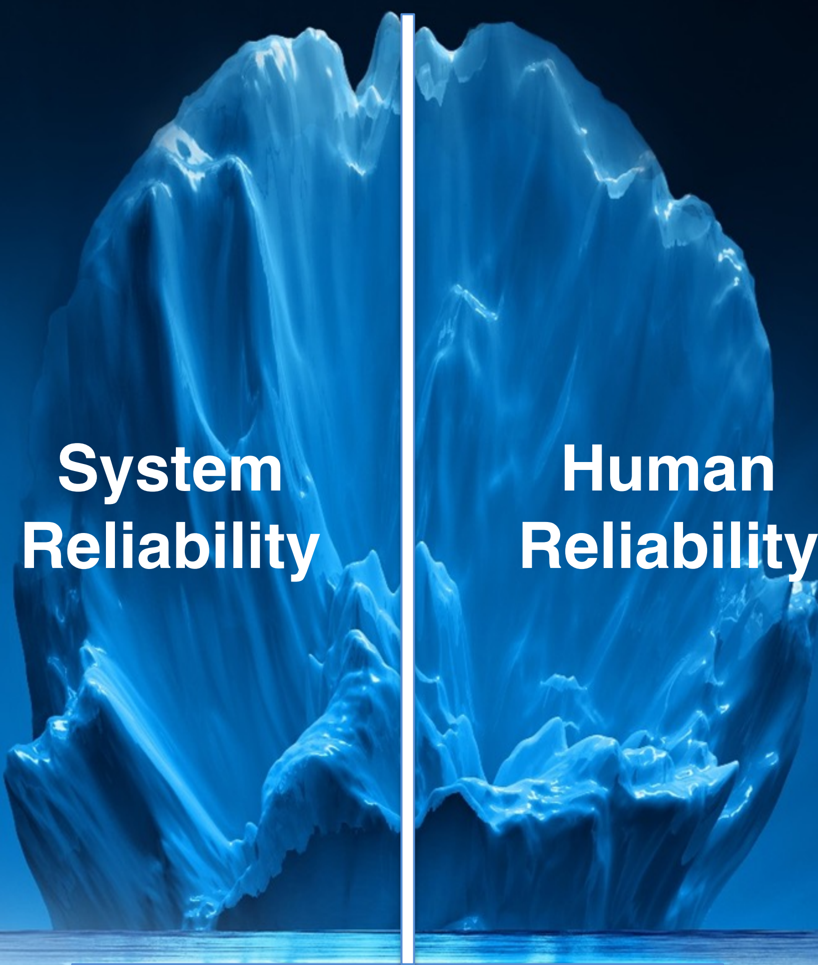
Flipping the Iceberg



U.S. and Canadian Operators Accident Rates by Year

Annual Fatal Accident Rates 1959 through 2018

Rest of the world
U.S. & Canadian operators

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- Safety Management Systems

50, 40, 30, 20, 10, 0

1959, 1962, 1966, 1970, 1974, 1978, 1982, 1986, 1990, 1994, 1998, 2002, 2006, 2010, 2014, 2018

Annual Fatal Accident Rates 1999 through 2018
(per million departures)
Rest of the world
U.S. & Canadian operators
1.0, 0.8, 0.6, 0.4, 0.2, 0.0
1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018

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

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Reasons Organizations Have Adopted the Standard

I. The Why

- 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.

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Collaborative Just Culture® Program

II. The What

- The world's first just culture standard
- A program to help achieve high reliability through workplace justice and collaboration
- Evidence-producing → evidence-based standard
- Documented, monitored, and measured
- Independently audited by a third-party

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New Public Release

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

Download the standard here:

https://sgcpartners.com/standard/

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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

Prepared by
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Albuquerque, New Mexico 87185 and Livermore, California 94550

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Electronic copy available at: http://ssrn.com/abstract=1122882

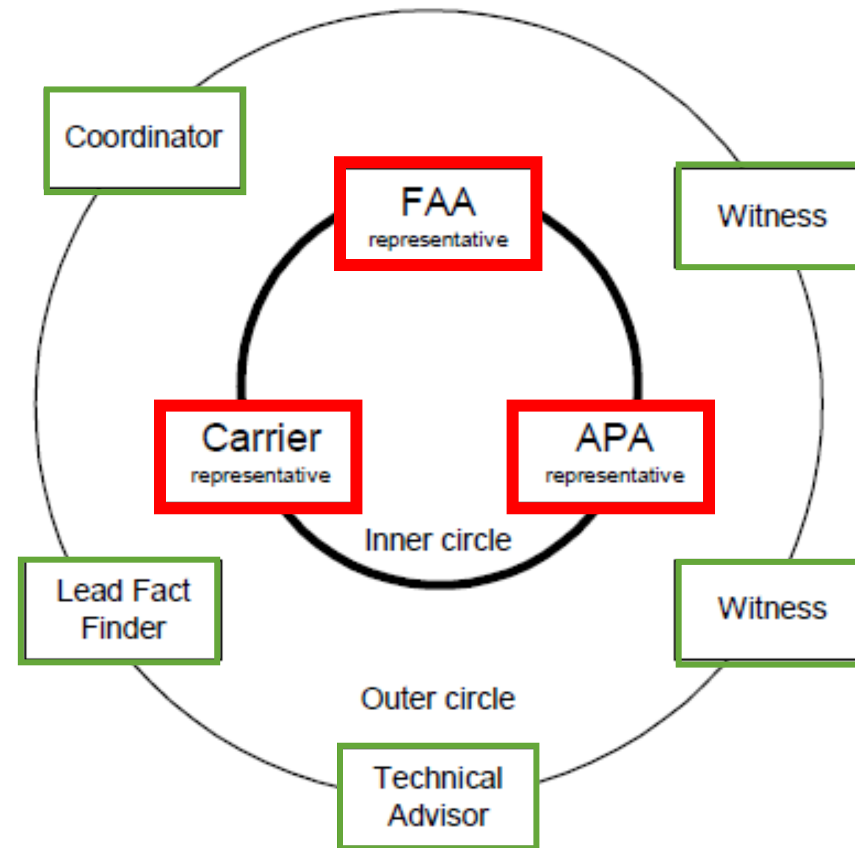

Figure 2. The ERT represented as an inner circle consisting of the three representatives, and an outer circle that provides information, opinions, and other process support. This is a schematic diagram, not a literal map of the ERT meeting.

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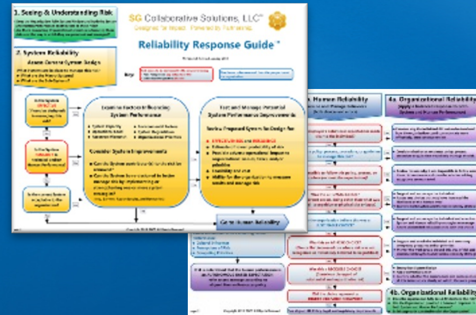
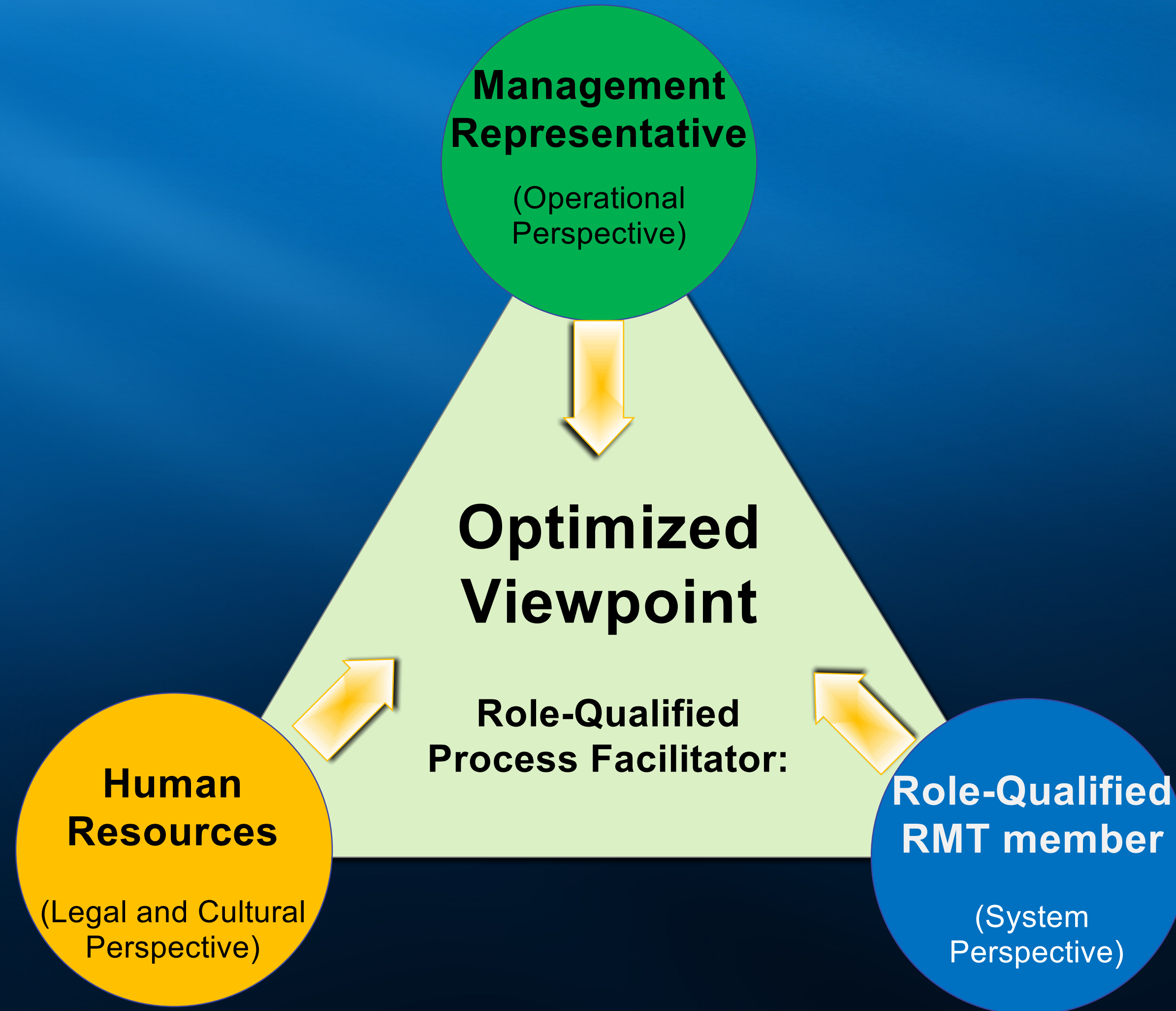
CJCP: A Tool, a Process, and a Program





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Seven Important Elements

COLLABORATIVE JUST CULTURE® (CJC) PROGRAM QUALIFICATION STANDARD 11

CJC.1 EXECUTIVE LEADERSHIP AND GOVERNING BODY RESPONSIBILITIES 12

CJC.2 LABOR ASSOCIATION INVOLVEMENT (WHEN APPLICABLE) 12

CJC.3 RELIABILITY MANAGEMENT TEAM 13

CJC.4 COLLABORATIVE JUST CULTURE PROGRAM POLICY 15

CJC.5 TRAINING REQUIREMENTS 18

CJC.6 TOOLS 22

CJC.7 MEASUREMENTS AND SUSTAINMENT PLAN 23

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CJC.5 Training

Organizational Role	Minimum Currency Training Requirements (at least every two years)		
	Introduction	Operational Ability	Role Qualification SME Proficiency
Staff	✓		
Contractors (including physicians)	✓		
Senior executives	✓		
Vice-presidents and directors	✓	✓	
Managers/supervisors (including physicians in supervisory and/or quality review roles)	✓	✓	
Role-Qualified Specialists (SMEs such as human resources professionals; safety or quality or risk or performance improvement personnel; Collaborative Risk Review team members; Triad Review Team members; RMT Instructors and Consultant/Examiners)	✓	✓	✓

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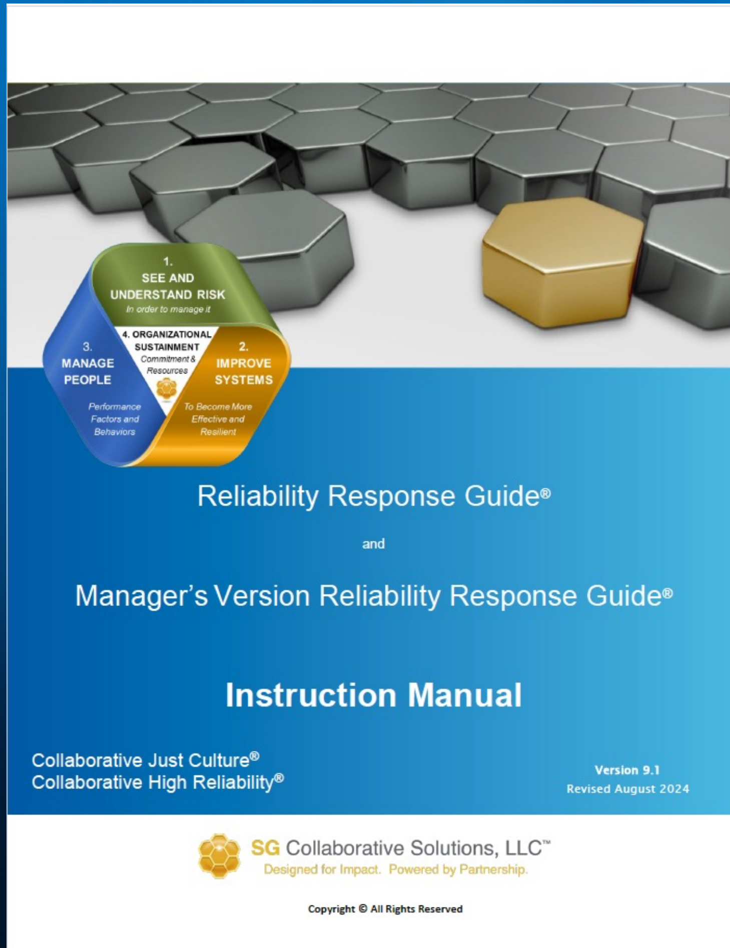
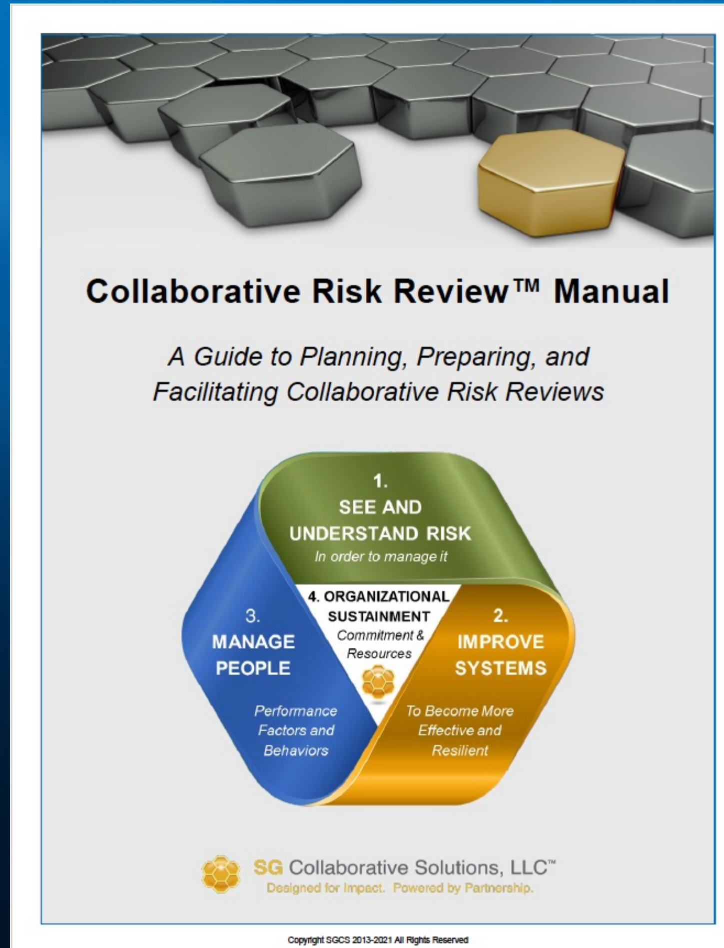
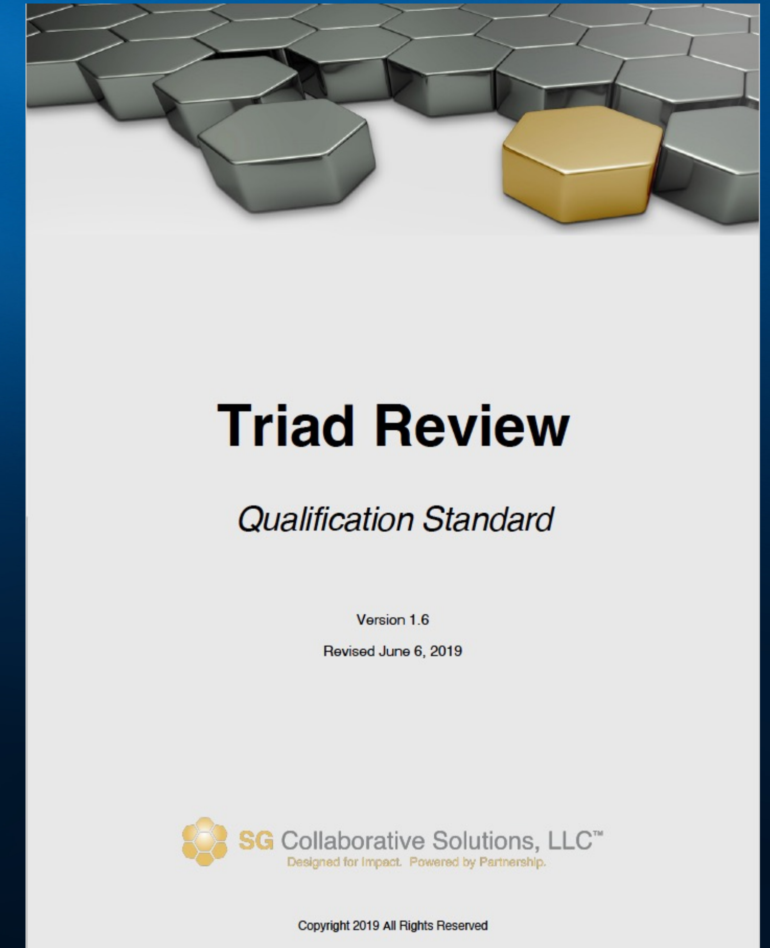
Tools and Processes







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CJCP Sequenced Integration

Phase 1: Development

Goal:
Begin Strategic Integration

- Executive Engagement
- Labor Involvement (if applicable)
- Policy Alignment
- RMT Selection
- Begin Role-Qualification Proficiency Training:
  - RMT, HR, Safety/Quality Risk

Key Benefit:
Set Program Expectations

Phase 2: Education

Goal:
Train Workforce

- Operational Ability:
  - Executives
  - Departmental Directors
  - Managers and Supervisors
- Non-Supervisory Staff Introduction:
  - Employees
  - Contractors

Key Benefit:
Re-Align Culture

Phase 3: Qualification

Goal:
Prepare for Audit

- Risk Reporting System
- Collaborative Risk Review Process
- Triad Review Process
- Sustainment Plan
- Program Qualification
  - Independent audit

Key Benefit:
See, Understand, & Manage Risk

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Recurring Audits

Independent, biennial audits (every 2 years):

- Initial audit examines the program infrastructure
  - ✓ (Commitment, RMT, policies, training, tools, sustainment & measurement plan)
- Requalification audits examine the organization's documenting, monitoring and measuring

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CJC.7 Sustainment Plan and Internal Evaluation

- **Sustainment Plan:** The organization shall document a CJCP sustainment plan.
- **Internal Evaluation:** The organization shall specify the process for conducting ongoing measurements and an annual internal evaluation and reporting the results
- **Periodic Review Meetings with Executive Leadership**
- **Annual Reports to the Governing Body**

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Fair and Consistent Treatment of Employees

Purpose: This section assesses the organization's use of evidence-based processes and tools to evaluate employees fairly and consistently.

Process Evaluated	Documentation	Source	Assessment
A. Employment terminations	Case reviews	Human Resources	(Red-Yellow-Green)
B. Other employee disciplinary actions	Case reviews	Human Resources	(Red-Yellow-Green)
C. Triad Reviews	Case reviews	Human Resources	(Red-Yellow-Green)
D. Performance versus Behavior Management	• Performance Improvement Plans • Behavioral Coaching and Counseling	All Departments	(Red-Yellow-Green)

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2 Collaborative Management of Risk

Purpose: This section assesses how the organization sees, understands, and manages risk, including responses to all findings and recommendations:

Process Evaluated	Documentation	Source	Assessment
E. Fact Gathering	• Taxonomy • Findings • Recommendations	• Human Resources • Quality/Safety/Risk • Performance Improvement	(Red-Yellow-Green)
F. Collaborative Risk Reviews	• Taxonomy • Findings • Recommendations	Quality/Safety/Risk	(Red-Yellow-Green)
G. Triad Reviews	• Taxonomy • Findings • Recommendations	• Human Resources • Quality/Safety/Risk • Performance Improvement	(Red-Yellow-Green)
H. Risk Reporting (vs. Event Reporting)	• Reporting system name • Ratio of risks to events reported	All departments	(Red-Yellow-Green)

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3 Perception of Culture Survey

Purpose: This section provides a survey for assessing the perception of the organizational culture and workplace justice. The questions should be reviewed and approved by the Reliability Management Team.

The survey responses should be assessed by:

I. Senior executives,
J. Managers/supervisors,
K. Frontline staff,
L. Fact-Gatherers.

Results should also be documented by department. The survey should be voluntary but include a representative sampling from each department. **No information identifying individuals by name should be collected.**

Work Group Perspective	Documentation	Source	Assessment
I. Senior Executives/Vice Presidents	Survey	Individuals	(Red-Yellow-Green)
J. Directors/Managers/Supervisors	Survey	Individuals	(Red-Yellow-Green)
K. Frontline Staff	Survey	Individuals	(Red-Yellow-Green)
L. Quality/Safety/Risk/Performance Improvement Departments	Survey	Individuals	(Red-Yellow-Green)

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The Ascent to CHRO

A Guided Transformation

Collaborative High Reliability® Organization Certifications

Tier 3

Tier 2

Tier 1

Additional 12-24 months

Collaborative Just Culture Program Qualification

Initial 3-6 months

Quality Management / ISO 9001

Optional

Federal, State, and/or Local Authority Accreditation or Licensure

Accreditation

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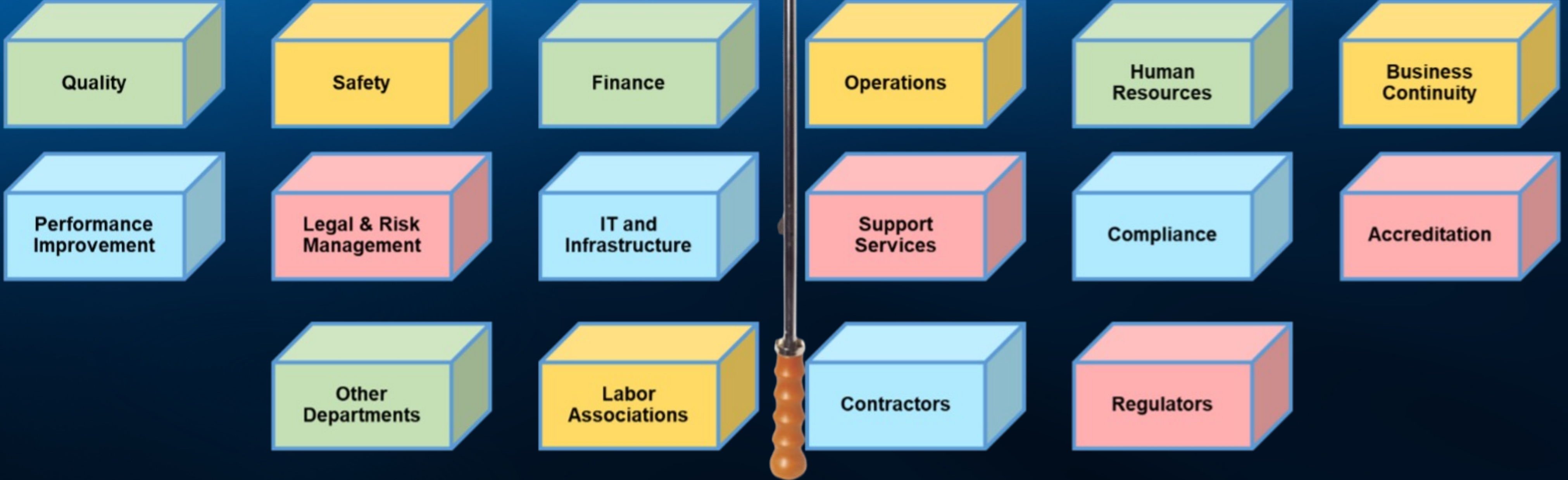
CHRO Umbrella

Collaborative High Reliabillity®

- Collaborative Just Culture Program
  - Reliability Management Team
- Reliability Management System



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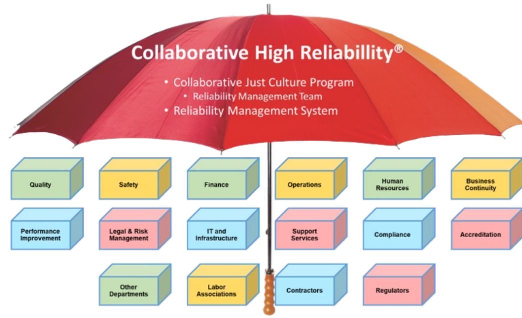
Collaborative High Reliability® Organization

Alignment



Sequence of Reliability

Taxonomy

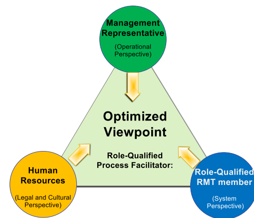
Taxonomy	Feature: Not Documented	Feature: Documented, Monitored, & Measured	Feature: Aligned	Feature: Integrated
Activity	✓			
Process		✓		
Program		✓	✓	
System		✓	✓	
Integrated System		✓	✓	✓

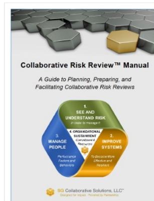
Collaborative Just Culture® Program

- The world's first just culture standard
- A program to help achieve high reliability through workplace justice and collaboration
- Evidence-producing ➡ evidence-based standard
- Documented, monitored, measured, aligned and integrated
- Independently audited by a third-party

Tools

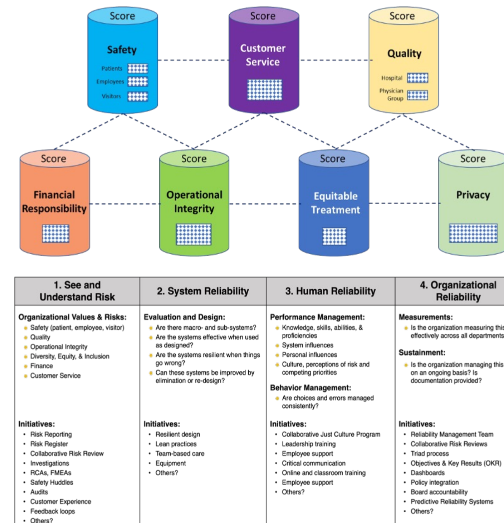
Processes





Program

Integrated Systems



Teams

Sustainable Benefits

Collaborative High Reliability® Organization

Beneficiaries	Tangible Benefits	Intangible Benefits
Employees	Structured engagement and collaboration with team members	Enhanced culture, employee morale, and confidence in leadership
Physicians & APPs	Improved patient outcomes	Enhanced culture, physician and APP morale, and confidence in leadership
Patients & Visitors	Improved customer satisfaction – safety, quality, privacy, equity, and access to care	Hospital and clinic reputational enhancement
Benefactors and Stakeholders	Positive financial performance and competitive advantage	Improved stewardship
Regulators	Fewer fines, penalties, and legal actions	Positive recognition by regulators

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CHRO Taxonomy

Taxonomy	Feature			
	Not Documented	Documented, Monitored, & Measured	Aligned	Integrated
Activity	✓			
Process		✓		
Program		✓	✓	
System		✓	✓	
Integrated System		✓	✓	✓

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Stranded Astronauts with Incompatible SpaceX And Boeing Spacesuits

NASA didn't require contractors to produce cross-compatible systems for the Commercial Crew Program

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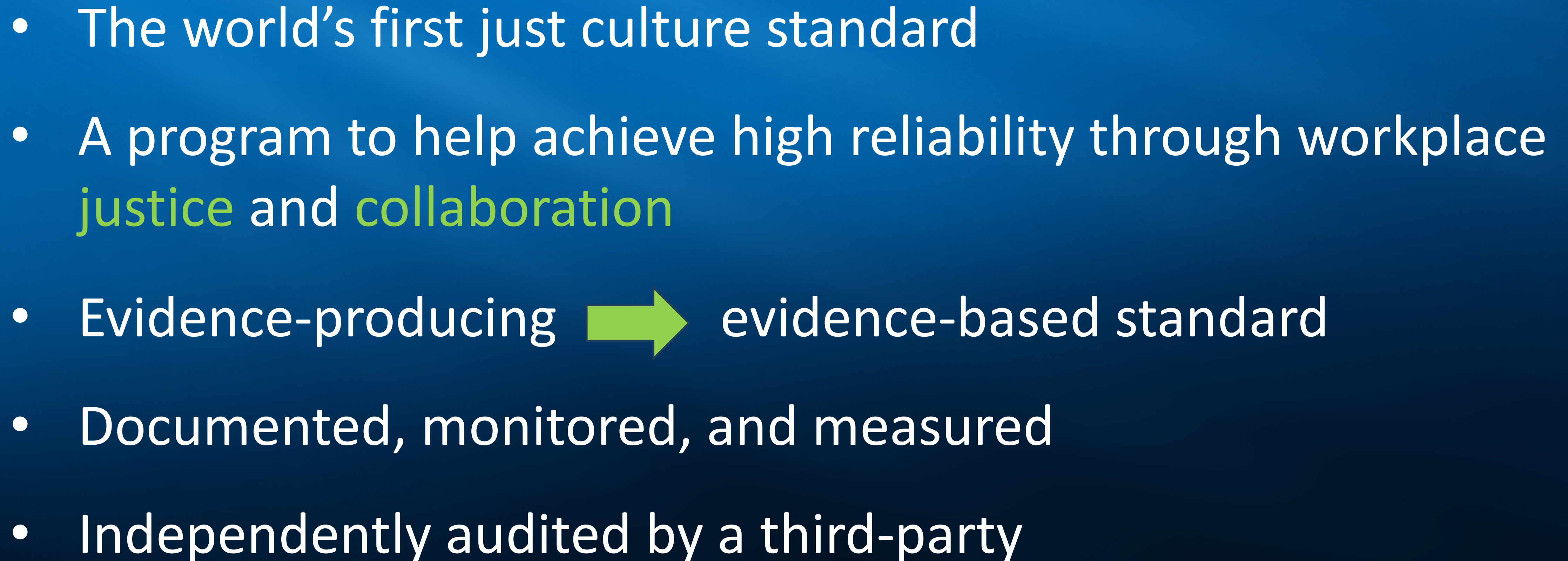
Collaborative Just Culture® Program Summary



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Statewide Adoption

Kansas Healthcare Collaborative and Kansas Hospital Association:

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

KHC will utilize the three key metrics to measure the effectiveness of this standard and publish peer-reviewed results to facilitate adoption of the standard across all US hospitals.

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Discussion

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Recent Articles

By K. Scott Griffith

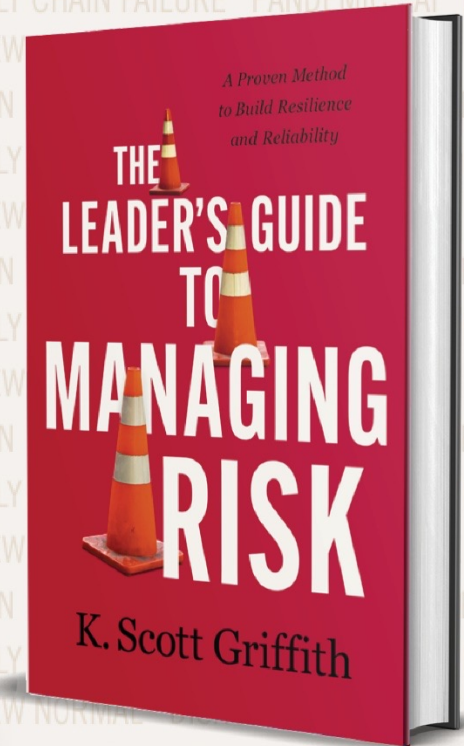
- Chief Healthcare Executive:

  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/

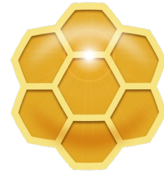
https://leadersguidetomanagingrisk.com



A proven method to build RESILIENCE and RELIABILITY

by K. Scott Griffith

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:
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