Three Blind Mice: Achieve a Shared Vision for Compliance, Risk and Quality

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Children’s Hospital New Orleans

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VP Compliance & Regulatory
Lafayette General Medical Center

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Vice President
Compliance Partners

Objectives

- Obstacles to creating a unified approach to healthcare compliance, risk, and quality initiatives
- Achieving integration through the development of shared goals
- Leveraging technology and data to break down communication silos
<table>
<thead>
<tr>
<th>Poll Question 1: Who's in the room?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Compliance Professional</td>
</tr>
<tr>
<td>2. Risk Professional</td>
</tr>
<tr>
<td>3. Quality Professional</td>
</tr>
<tr>
<td>4. Privacy Professional</td>
</tr>
<tr>
<td>5. General Counsel</td>
</tr>
<tr>
<td>6. Consultant/Vendor</td>
</tr>
<tr>
<td>7. Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poll Question 2: Which area is your primary focus?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Compliance</td>
</tr>
<tr>
<td>2. Quality</td>
</tr>
<tr>
<td>3. Risk</td>
</tr>
<tr>
<td>4. Other</td>
</tr>
</tbody>
</table>
Obstacles to Creating a Unified Approach

- Limited Resources
- Adaptability
- Track Record
- Regulations
- Culture
- Silos

1. Limited Resources
2. Adaptability
3. Track Record
4. Regulations
5. Culture
6. Silos

Limited Resources

- “Quick fix”- Process are only surface level versus engrained into the culture and operations
- Implementation and scalability of multiple “best practices” are unsustainable
- With staff turnover, new process are never fully accepted and implemented

HEALTHCARE TURNOVER RATE

Source: Data from the NSI Nursing Solutions Inc. Report: 2017 National Health Care Retention & RN Satification Report
Adaptability

Adaptability is not an inborn trait; it’s a **skill** people learn

- Departments that hard-code processes or technologies cannot react to change
- Adaptability requires mastery of many skillsets

![Skill Diagram](image)

**Adaptability**

**Traditional**

Hire for other necessary skills and experience and hope employee is an adaptable worker

**Future**

Intentional Workforce

Diversification

- Support employee moves inter-departmentally; Retrain valuable employees
- Focus on creating a multi-generation teams with diverse personality profiles
Poll Question 3: What is your primary training method?

- 1. Technology Based (LMS)
- 2. Classroom/Instructor-Led Training
- 3. Group Discussion
- 4. Email Distributions
- 5. Other
Track Record

Lack of Measurement

- How are you measuring and communicating success?
  - Why should you always communicate success? Lessened perception of program's impact can decrease funding and executive support

- What metrics (time, budget, effort, etc.) can be measured today that can be monitored over time to demonstrate improvement?

Track Record: Dashboards
Patient Safety Culture Survey

Dimensions of Culture

- Teamwork within units
- Supervisor/manager expectations & actions promoting patient safety
- Organizational learning – continuous improvement
- Management support
- Overall perceptions
- Feedback & communication about error
- Communication openness
- Frequency of event reporting
- Teamwork across units
- Staffing
- Handoffs & transitions
- Nonpunitive response to error

Patient Safety Culture Survey Results
**Wins**
1. Teamwork within units
2. Hospital Management Support for Patient Safety
3. Supervisor/Manager Expectations & Actions

**Opportunities**
1. Hospital Handoffs & Transitions
2. Non-punitive Response to Error
3. Staffing

### Safety Culture Composites

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Handoffs &amp; Transitions</td>
<td>44%</td>
</tr>
<tr>
<td>Nonpunitive Response to Error</td>
<td>45%</td>
</tr>
<tr>
<td>Staffing</td>
<td>50%</td>
</tr>
<tr>
<td>Communication Openness</td>
<td>58%</td>
</tr>
<tr>
<td>Teamwork across Hospital Units</td>
<td>65%</td>
</tr>
<tr>
<td>Overall Perceptions of Safety</td>
<td>65%</td>
</tr>
<tr>
<td>Frequency of Events Reported</td>
<td>67%</td>
</tr>
<tr>
<td>Feedback &amp; Communication re: Error</td>
<td>69%</td>
</tr>
<tr>
<td>Organizational Learning-Continuous...</td>
<td>70%</td>
</tr>
<tr>
<td>Supervisor/Manager Expectations &amp; Actions</td>
<td>75%</td>
</tr>
<tr>
<td>Hospital Mgmt Support for Patient Safety</td>
<td>78%</td>
</tr>
<tr>
<td>Teamwork within Units</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Culture of Safety Pulse Survey

**LGH 2016**

- Patient Safety Grade in my area
- Safety Report Submitted in past 12 mo
- Hospital Units Work Well Together
- Unit Team Work
- Handoff Communication
- I would feel safe being treated here
- I know who to ask regarding patient safety
- I receive feedback about my performance
- Encouraged to report concerns
- Culture of Safety in my area
Regulatory Burden

Healthcare is one of the most complex and heavily regulated industries in US with more than 200,000 pages of laws, regulations, and standards

$39 BILLION

Spent by health systems, hospitals, and post-acute care providers each year on non-clinical regulatory requirements

$7.6 MILLION

Per community hospital spent annually to comply

- This number rises to $9 million for hospitals with post-acute care
- For the largest hospitals, cost can exceed $19 million annually

Source: Data from the American Hospital Association Report: Regulatory Overload - Accessing Regulatory Burden on Health Systems, Hospitals and Post-acute Care
Regulatory Agencies

Healthcare is “compliant” if...

1. It meets quality standards;
2. Is medically necessary;
3. Is provided by qualified physicians and staff;
4. Is provided without improper financial incentives;
5. Is provided in a way that respects patient’s rights;
6. Is provided in an approved facility;
7. Is reimbursed correctly;
8. Is documented, charged, and billed correctly.

VALUES

Laws / Rules

OIG Exclusions
Scope of Practice/Licensure Issues
Stark/AKS
Sunshine Act
OCR/HIPAA
False Claims Act/Overpayments Rule
CMS CoPs
Culture: How Generations Define “Healthy”

The Millennials

Source: MobileSmith Report: How Millennials are Redefining Healthcare Today: Are You Behind?
Do you snapchat hand hygiene?
Poll Question 4: Who owns Joint Commission accreditation at your organization?

1. Compliance
2. Risk
3. Quality
4. Other
Poll Question 5: Who owns Conditions of Participation?

1. Compliance
2. Risk
3. Quality
4. Other

SILOS: Redesigning Systems

1. **Option 1**
   Merge compliance, risk, and quality functions into one program or department that reports to the same leader in the organizational hierarchy

2. **Option 2**
   Create a mechanism for collaboration between Compliance, Risk, and Quality managers
Poll Question 6: Which one are you?

1. Option 1
2. Option 2

Enterprise Risk Management

By collaborating to address overlapping issues and functions, leaders are more efficient in addressing shared interests and better able to focus on their distinct functions.
Technology

- Incident reporting
- Performance improvement tracking
- Governance Risk and Compliance (GRC) Platforms
Part II

- Achieving integration through the development of shared goals
- Leveraging technology and data to break down communication silos

What is Enterprise Risk Management?

An interdisciplinary process through which an organization identifies, analyzes, prioritizes, and addresses the risks and opportunities that can affect the achievement of its strategic objectives, whether in positive or negative ways.


<table>
<thead>
<tr>
<th>Traditional Risk Management</th>
<th>Enterprise Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk = negative outcome imposed by an external, or third-party force</td>
<td>Risk = any issue affecting the organization’s ability to meet its objectives</td>
</tr>
</tbody>
</table>
Enterprise Risk Management (ERM)

- Utilizes a process or framework for **assessing**, **evaluating**, and **measuring** all of an organization's risks.
- Any event that can adversely affect the objective/organization:
  - Asset preservation
  - Failure to grow
  - Failure to execute on opportunities
- Consider designation of Chief Risk Officer
Areas of Risk

<table>
<thead>
<tr>
<th>Medicare Compliance</th>
<th>Internal Financial Controls</th>
<th>HIPAA Privacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Security</td>
<td>General Liability / Property &amp; Casualty</td>
<td>Human Resources</td>
</tr>
<tr>
<td>Safety &amp; Security</td>
<td>Regulatory</td>
<td>Healthcare Fraud &amp; Abuse</td>
</tr>
</tbody>
</table>

Leading Trends for Effective ERM

- Increased focus on risk “intelligence” and risk assessment
- Analytics and other predictive tools for early detection of – and response to – emerging risks
- More frequent and dynamic assessment of top risks
- Management-level and Board-level accountability for the ERM process and for each key risk
- Integration of risk management and strategy / major initiatives
- Improved discipline and better documentation
- Key Risk Indicators vs. Key Performance Measures
Poll Question 6: Do you have an enterprise risk function?

1. Yes
2. No

ERM Committee

Responsibilities

- Provide education/in-services regarding changes in rules and regulations of relevant agencies
- Provide clarification and guidance on current regulations
- Assess processes to determine if facilities are in compliance with current regulations
- Standardize processes across organization, as appropriate
- Share methods, technology, and best practice
- Create toolkits for continued readiness
- Develop and monitor Key Risk Indicators
Agencies/Areas Monitored

<table>
<thead>
<tr>
<th>The Joint Commission (TJC)</th>
<th>Centers for Medicare and Medicaid Services (CMS) Conditions of Participation</th>
<th>Medicare Compliance (Billing/Coding)</th>
<th>Office of Inspector General (OIG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health and Hospitals (DHH)</td>
<td>HIPAA / Privacy</td>
<td>Department of Insurance</td>
<td>Office of the National Coordinator (ONC) IT Security</td>
</tr>
</tbody>
</table>

ERM Committee

Functions

- Define the scope of the program
- Approve key policies & procedures
- Require periodic, substantive reporting by management
- Ask questions
- Oversight of external auditor, internal audit function, & compliance program
- Monitoring effectiveness of internal controls processes
- Approve and monitor Key Risk Indicators
Key Performance Indicators (KPIs)

Key performance indicators (KPIs) are metrics used to measure key business processes that reflect strategic performance:

**Inpatient flow**
- Inpatient raw mortality rate
- Patient vs Staff Ratios
- Harm events per 1,000 patient days
- Readmission rate
- Occupancy rate
- Average length of stay
- Average cost per discharge

**Revenue cycle**
- Total operating margin
- A/R days due to coding
- Total A/R days outstanding
- Average cost per discharge
- Cash receipt to bad debt
- Claims denial rate
- Days of cash on hand
Key Risk Indicators (KRI) are critical predictors of unfavorable events that can adversely impact organizations. They monitor changes in the levels of risk exposure and contribute to the early warning signs that enable organizations to report risks, prevent crises, and mitigate them in time.

Relationship between KPIs and KRI

- **KPIs**
  - Measure Historical Performance
- **KRI**
  - Predict Future Risk
Developing Key Risk Indicators

Identify relevant metrics linked to organization’s objectives

Profitability

- Increase Revenues
  - Strategic Initiative #1
    - Potential Risk
      - KRI

- Reduce Costs
  - Strategic Initiative #2
    - Potential Risk
      - KRI

  - Strategic Initiative #3
    - Potential Risk
      - KRI

  - Strategic Initiative #4
    - Potential Risk
      - KRI

Source: COSO Report: Developing Key Risk Indicators to Strengthen Enterprise Risk Management

Developing Key Risk Indicators

Analyze a risk event that has affected the organization in the past (or present) and then work backwards to pinpoint intermediate and root cause events

Source: COSO Report: Developing Key Risk Indicators to Strengthen Enterprise Risk Management
Core Elements of Well-Designed KRIs

- Allow for measurable comparisons across time and business units
- Consume resources efficiently
- Developed consistently across the organization
- Provide opportunities to assess the performance of risk owners on a timely basis
- Provide an unambiguous and intuitive view of the highlight risk
- Based on established practices or benchmarks

Key Risk Indicator Assignment

- Identify 2-3 Key Risk Indicators for your area:
  - Must be a predictor of risk
  - Can be simple
  - Must be measurable and reportable monthly
  - Data must be available (not a labor intensive process)
  - May be something that you are already monitoring
- Determine low, moderate, and high risk scores
- Identify responsible person
ERM Committee KRI

**Compliance**
- One Day Stays
- Medical Necessity
- Meaningful Use

**Quality**
- Surgical Site Infections
- CLABSI/CAUTI

**Legal**
- Dollar Amounts of Settlements
- Number of New Lawsuits
- Accrued Reserve Dollars for Settlements

**Finance**
- Internal Controls
- Executive Expenses
- Payroll Testing

**Patient Safety**
- Barcode Scanning Rates
- Hand Hygiene
- Universal Protocol
- Opioid Prescription Reduction

**Environmental**
- Generator Checks
- Emergency Preparedness

**Human Resources**
- Drug Diversion
- Employee Incidents
- Turnover % in Key Position

**IT/Privacy**
- Virus Email Received
- Inactive Users Disabled
- Firewall Penetration Attempts

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<table>
<thead>
<tr>
<th>Key Risk Indicators Dashboard</th>
<th>Risk Tolerance Key</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Compliance</strong></td>
<td><strong>Medicare Compliance</strong></td>
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<tr>
<td></td>
<td>1 Day Stays</td>
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<tr>
<td></td>
<td>Admitted from the ED</td>
</tr>
<tr>
<td></td>
<td><strong>12.5%</strong></td>
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<td><strong>77.4%</strong></td>
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<td></td>
<td><strong>73.0%</strong></td>
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<tr>
<td></td>
<td><strong>81.0%</strong></td>
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<tr>
<td><strong>ED/ICU</strong></td>
<td><strong>Transfer Requests Accepted</strong></td>
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<tr>
<td></td>
<td>173</td>
</tr>
<tr>
<td></td>
<td>102</td>
</tr>
<tr>
<td></td>
<td><strong>Transfer Requests Refused</strong></td>
</tr>
<tr>
<td></td>
<td>281</td>
</tr>
<tr>
<td></td>
<td>109</td>
</tr>
<tr>
<td></td>
<td><strong>Transfer Out</strong></td>
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<tr>
<td></td>
<td>369</td>
</tr>
<tr>
<td></td>
<td>164</td>
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<tr>
<td></td>
<td><strong>Transfer Requests Refused</strong></td>
</tr>
<tr>
<td></td>
<td>28</td>
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<tr>
<td></td>
<td>11</td>
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<tr>
<td><strong>Device Utilization</strong></td>
<td><strong>Device Utilization</strong></td>
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<tr>
<td></td>
<td><strong>Multiple Stents</strong></td>
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<tr>
<td></td>
<td>64</td>
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<td></td>
<td>27</td>
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<tr>
<td><strong>Regulatory Compliance</strong></td>
<td><strong>Regulatory Compliance</strong></td>
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<tr>
<td></td>
<td><strong>Meaningful Use</strong></td>
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<td></td>
<td>6</td>
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<td>6</td>
</tr>
<tr>
<td></td>
<td><strong>Trace Compliance</strong></td>
</tr>
<tr>
<td></td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td>99%</td>
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<tr>
<td><strong>Human Resources</strong></td>
<td><strong>Human Resources</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Employee Injuries</strong></td>
</tr>
<tr>
<td></td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>17</td>
</tr>
<tr>
<td></td>
<td><strong>For Cause Drug Tests</strong></td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Turnover (Key Positions)</strong></td>
</tr>
<tr>
<td></td>
<td>0</td>
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<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td><strong>Employee Counseling</strong></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td>71</td>
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<tr>
<td><strong>Data Security</strong></td>
<td><strong>Data Security</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Virus Email Received</strong></td>
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<td></td>
<td>2,386</td>
</tr>
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<td>2,386</td>
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<tr>
<td></td>
<td><strong>Inactive Users Disabled</strong></td>
</tr>
<tr>
<td></td>
<td>387</td>
</tr>
<tr>
<td></td>
<td>198</td>
</tr>
<tr>
<td></td>
<td><strong>Firewall Penetration Attempts</strong></td>
</tr>
<tr>
<td></td>
<td>30,783,672</td>
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<td></td>
<td>31,150,685</td>
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<tr>
<td></td>
<td><strong>Number of Websites Blocks</strong></td>
</tr>
<tr>
<td></td>
<td>2,562,719</td>
</tr>
<tr>
<td></td>
<td>2,562,719</td>
</tr>
<tr>
<td></td>
<td><strong>Accessing Emails Blocked</strong></td>
</tr>
<tr>
<td></td>
<td>285,400</td>
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<td>285,400</td>
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</tbody>
</table>

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26
Meeting Agenda

I. WELCOME
   - Executive Leader (5 minutes)

II. RULES/REGULATIONS EDUCATION AND UPDATES
    - CoPs/TJC
    - CMS
    - HIPAA
    - ONC
    - OIG (10 minutes)

III. POLICY & PROCEDURES
     - Patient Status Changes
     - Sentinel Event
     - Texting (10 minutes)

IV. EDUCATION/POLICY REVIEW REGARDING PEC/CEC
    - In-service/Education by Subject Matter Expert
    (20 minutes)

V. KEY RISK INDICATORS
   - Sandy Keller, Vice-President/LGH Corporate Compliance & Regulatory (10 minutes)
   — BREAK —

IV. BREAK-OUT SESSIONS
    (45 minutes)

V. WRAP UP
   - Team Discussion (15 minutes)

Reporting Key Risk Indicators

Operational Managers
All KRIrs within their scope, need real-time reporting

Senior Management
KRIrs for risks and opportunities with significant potential impact to the organization, less frequent (e.g. monthly)

Board of Directors
Only most significant KRI data to be confident that risk management is functioning as designed and approved, aggregated data for strategic evaluation
LGH: ERM Evolution

Part III
High Reliability

“Collective mindfulness’ in which all workers look for, and report, small problems or unsafe conditions before they pose a substantial risk to the organization and when they are easy to fix.”

-Weick and Sutcliffe 2007

5 Traits of High Reliability Organizations

01 Sensitive to operations

02 Reluctant to accept “simple” explanations

03 Preoccupation with failure for problems

04 Defer to expertise

05 Resilient
Typical Healthcare Improvement Model

**Usual Improvement Approach**

- Best practices, toolkits, protocols, checklists
- “One-size-fits-all”

High Reliability Model

**Leadership Commitment**
- Board
- CEO/Management
- Physicians
- Quality Strategy
- Quality Measures
- Safe Adoption of IT

**Adoption of Safety Culture**
- Trust
- Accountability
- Identifying Unsafe Conditions
- Strengthening Systems
- Assessment

**Robust Process Improvement**
- Methods
- Training
- Spread

*Stages of maturity*

*Beginning* ➔ *Developing* ➔ *Advancing* ➔ *Approaching*
Leadership Commitment

A RADICAL COMMITMENT TO TEAMWORK
The traditional social structure of health care organizations is extremely hierarchical. To achieve high reliability, health care organizations must commit to a kind of teamwork that erases the old hierarchical structures completely.
Robust Process Improvement

Systematic Approach to Problem Solving
- Adoption of RPI tools accepted fully throughout organization
- Training in RPI is a high priority for all staff
- RPI tools utilized for all improvement work
- Patients and employees are engaged in redesigning care processes

Throughput Huddle

**What is it?**
Multidisciplinary team that meets twice a day to discuss throughput, wins, barriers, and concerns for the shift

**Why do we do it?**
- Drives high reliability/safety
- Drives communication
- Capture wins & connect staff
- Drives reward and recognition

**How?**
- All disciplines report to same room; 9:00AM and 3:30PM
- Use Capacity Management System on projector
- Use Dry Erase Board LIVE
- Same sequence for reporting
<table>
<thead>
<tr>
<th>Emergency Department Reports on</th>
<th>Food and Nutrition Reports on</th>
<th>Pharmacy Reports on</th>
</tr>
</thead>
<tbody>
<tr>
<td>• # of ED boarders</td>
<td>• Delays in patient meal delivery</td>
<td>• Medication shortages &amp; duration</td>
</tr>
<tr>
<td>• # of admits from previous day</td>
<td>• Down equipment that may impact meal</td>
<td>• Medication shortages resolved</td>
</tr>
<tr>
<td>• # of admits for that day of the week</td>
<td>• Dietitian staffing</td>
<td>• Medication delivery issues</td>
</tr>
<tr>
<td>• Status of admits that day</td>
<td></td>
<td>• Equipment issues &amp; delays</td>
</tr>
<tr>
<td>• Any external issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgery Reports on</th>
<th>Transport Reports on</th>
<th>Laboratory Reports on</th>
</tr>
</thead>
<tbody>
<tr>
<td>• # of surgery beds needed per service line</td>
<td>• Total TAT (turn around time) for the day vs. goal</td>
<td>• Lab instrumentation – working/not working, delays, and duration</td>
</tr>
<tr>
<td></td>
<td>• Delays (i.e. staffing issues, elevator, equipment)</td>
<td>• Manpower – staffing shortages for techs and phlebotomists</td>
</tr>
<tr>
<td><strong>Wins so far</strong></td>
<td>• If help needed between certain times</td>
<td>• Supply shortages or device difficulties</td>
</tr>
<tr>
<td>• Decreased PACU boarding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Less disruptions to progression of surgery cases</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICU Reports on</th>
<th>Radiology Reports on</th>
<th>Inpatient Units and Care Management Reports on</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Current bed status in ICU</td>
<td>• Equipment down &amp; duration</td>
<td>• Potential discharges (2x10s, 2x12s, 2x4s)</td>
</tr>
<tr>
<td>• Patients move out of ICU (and to where)</td>
<td>• Delays in any radiology modality (CXR, CT, MRI, US, Nuc Med)</td>
<td>• Needs prior to discharge</td>
</tr>
<tr>
<td>• Patients to bed in ICU</td>
<td>• How many procedures in IR and anesthesia cases</td>
<td>• Delays in discharge</td>
</tr>
<tr>
<td></td>
<td>• Any staffing shortages</td>
<td>• Bed availability at post acute facilities</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>
eForm Database

Alert: Lack of Signed Order
What is a “Just” Culture?

A Just Culture exists when team members trust each other, are rewarded for providing information about adverse outcomes and events, and are clear about their responsibilities regarding safe and compliant behavioral choices.

Most importantly, there is a shared accountability for risk avoidance.

Types of Behavior Involved in Errors

**Human Error:** an inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake

**At-Risk Behavior:** a behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified

**Reckless Behavior:** a behavioral choice to consciously disregard a substantial and unjustifiable risk
Recognize the Factors that Lead to Outcomes

- System Design
  - Values and Expectations
  - Behavioral Choices
  - Successful Outcomes

Attributes of a Fair and Just Culture

- Human errors are accepted as system flaws, not character flaws
- Emphasizes learning over blaming
- Promote an open discussion of near misses
- Organizational commitment to a fair and just culture for ALL team members
- Consequences for blatant disregard for risk or organizational policy
- Utilization of the Just Culture decision guide
Just Culture

- Just Culture is about a proactive learning culture where it’s not seeing events as things to be fixed, but seeing events as opportunities to improve the organization’s understanding of risk.
  - Fosters a cycle of trust, reporting, and improvement
  - Eliminates intimidating and disrespectful behaviors
  - Has a consistent and transparent process for evaluating accountability

- Just Culture is about changing staff’s perspective

- We want our people to:
  - Looking for the risks around me
  - Reporting errors and hazards
  - Helping to design safe systems
  - Making safe choices
    - Following procedure
    - Making choices that align with organizational values
  - Never signing for something that was not done

“People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

-Don Norman Author,
The Design of Everyday Things
Create a Culture of Coaching

“A coach is someone who can give correction without causing resentment.”
-John Wooden

“The single greatest impediment to error prevention is that we punish people for making mistakes.”
-Lucian Leape, M.D.

There is an inverse relationship between discipline and reporting.

Discipline \[ \uparrow \] Reporting \[ \downarrow \]

Balanced Accountability

What point on the spectrum best supports our goals?

Low Risk Environment \[ \uparrow \]
High Risk Environment

Blame Free Culture Punitive Culture
Managing the Three Behaviors

**Human Error**
*Product of Our Current System Design and Behavioral Choices*

- Manage through changes in:
  - Choices
  - Processes
  - Procedures
  - Training
  - Design
  - Environment

**At-Risk Behavior**
*A Choice: Risk Believed Insignificant or Justified*

- Manage through:
  - Removing incentives or at-risk barriers
  - Create incentives for healthy behaviors
  - Increase situational awareness

**Reckless Behavior**
*Conscious Disregard of Substantial Unjustifiable Risk*

- Manage through:
  - Remediator action
  - Disciplinary action

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For the specific details mentioned in the diagram, please refer to the image and context. The text below is a simplified representation of the key points:

- **Human Error**
  - Human Error
  - Risk Behavior
  - Reckless Behavior
  - Product of Our Current System Design and Behavioral Choices

- **At-Risk Behavior**
  - Actions to Consider
  - A Choice: Risk Believed Insignificant or Justified

- **Reckless Behavior**
  - Actions to Consider
  - Conscious Disregard of Substantial Unjustifiable Risk
Just Culture Doesn’t *Only* Support Safety Culture

- Encourage Reporting
- Support Learning Organization
- Focus on Systems v. Individuals
- Coaching v. Punishing
- Root Cause Analysis
- Welcome and Embrace Surveillance
- Encourage Accountability and Ownership

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**Conclusion**

- Obstacles to creating a unified approach to healthcare compliance, risk, and quality initiatives
- Achieving integration through the development of shared goals
- Leveraging technology and data to break down communication silos