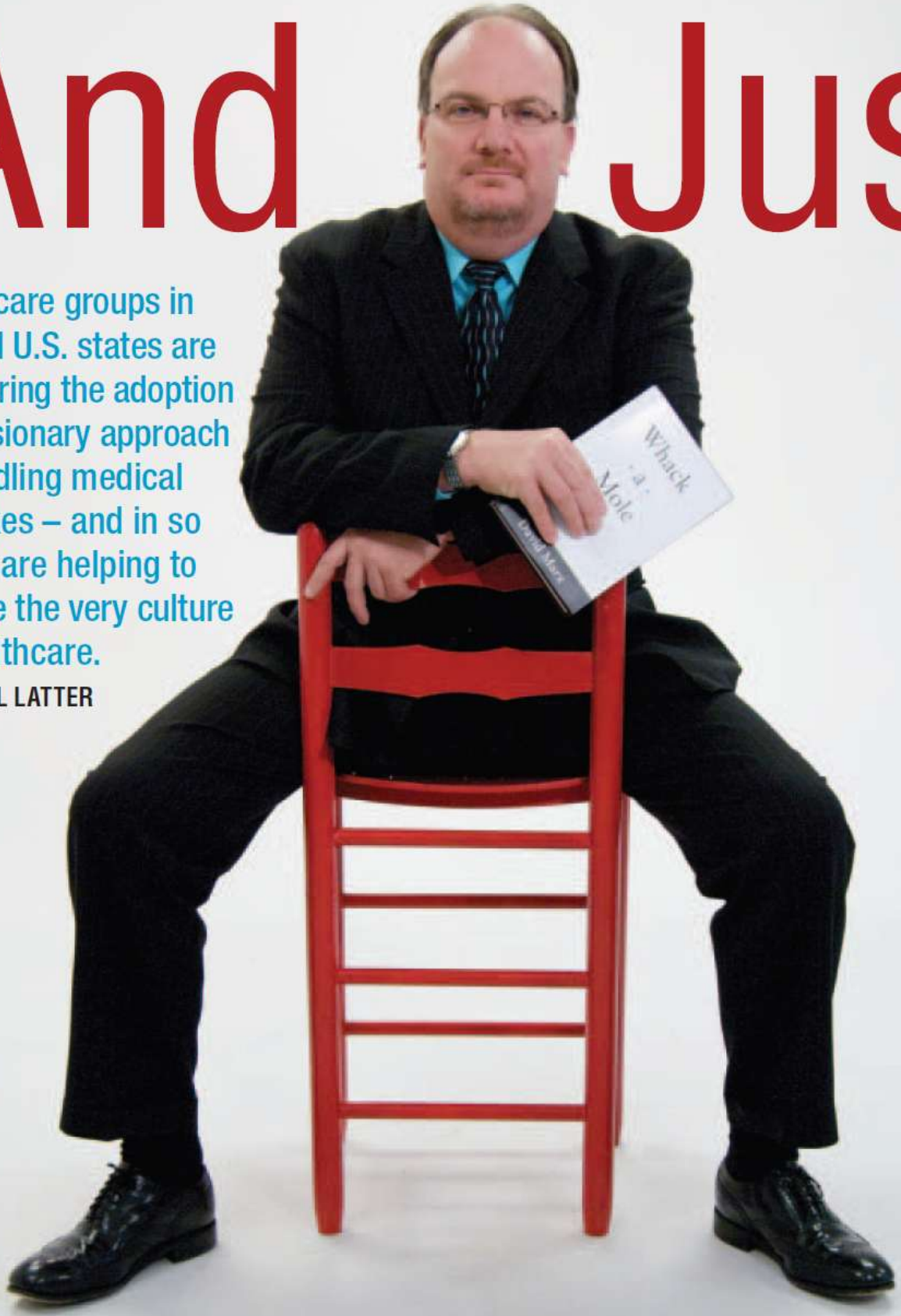
And Just

Healthcare groups in several U.S. states are pioneering the adoption of a visionary approach to handling medical mistakes – and in so doing, are helping to change the very culture of healthcare.

BY CAROL LATTER



ice For All

Across the country and around the globe, David Marx has spent the last decade or more spreading a message that has been slowly altering the way the world looks at mistakes – from pilot error in the aviation industry to medical errors in the healthcare field.

In our increasingly litigious society, Americans in particular have become known for suing first and asking questions later – and regulators and corporate leaders alike have found it all too easy to cave in to public pressure to "make people pay" for their mistakes.

The idea: to strike fear into people's hearts so they'll be driven by fear to avoid slip-ups.

The reality: punitive approaches have been proven ineffective in reducing preventable errors.

The reason: business or operating systems are rarely perfect, and humans – despite their best intentions – are fallible.

Despite decades of strict regulations and harsh penalties for errors, Marx says, "200,000 people die from medical error or hospital infection" in the U.S. each year. And in a climate of fear, medical errors are vastly underreported, reducing the chance for the healthcare system to learn from those mistakes.

Clearly, another approach is needed.

Marx advocates an approach he believes is both more humane and more effective – a middle ground between harsh punishment and a blame-free society. "Just Culture" calls for treating people fairly and encouraging open communication so that "near misses" can serve as learning tools to prevent future problems, and actual mistakes can be used to identify and correct root causes.

Under this model, healthcare organizations still investigate why an adverse incident took place, but they console employees who make honest mistakes and coach those involved in risky behavior. Sanctions are reserved for reckless acts.

A State of Justice

Healthcare organizations in a number of states – North Carolina, Missouri and California chief among them – have heeded Marx's "better way." They've spent the last several years pioneering the statewide adoption of his visionary approach, with impressive results.

North Carolina is one of a handful of states that have been launching statewide initiatives to engage

Theresa Manley, right, discusses Just Culture initiatives with fellow staff members. Manley is chair of the California Patient Safety Action Coalition, which has been promoting Marx's approach as a means of improving healthcare safety.

everyone – from regulators and healthcare leadership to individual physicians and nurses – in this alternate approach to improving patient safety and the overall tone of the workplace environment.

Dr. Carol Koeble, MD, MS, CPE, is director of the North Carolina Center for Hospital Quality and Patient Safety, an initiative of the North Carolina Hospital Association. The center was established in 2005 through grant funding to put North Carolina on the path to "having the safest, highest quality hospitals in the U.S."

When she arrived from Alaska four years ago to take the helm of the center, Dr. Koeble learned that the state board of nursing had invited Marx to speak about Just Culture, and that he was subsequently brought back to address a hospital association member meeting.

In talking to hospitals, she discovered that many were extremely interested in what Marx had to say. A subsequent statewide, day-and-a-half educational session attracted 130 people from 30 hospitals. This led, in short order, to the establishment of a statewide collaborative to provide participating healthcare organizations with a foundational platform and strategic goals. "We've been building statewide consensus for fair and just culture since that time," says Dr. Koeble.

The NC Quality Center has developed two collaboratives – an 18-month program that began in 2006 and attracted nine hospitals, and a second two-year program, begun in 2008, involving eight facilities. In addition to the collaborative programs, the center provides educational programs on a statewide, regional and local basis.

Three in-person educational sessions, regular teleconferences and coaching calls are offered to participating organizations, Dr. Koeble says. In addition, hospitals are provided with how-to materials created by Marx's company, including an assessment algorithm tool, to determine how to handle and respond to medical errors at the organizational level.

The North Carolina Board of Nursing is very much involved, and has adopted the Just Culture model to investigate "deviations from [standard] nursing practices. They've been piloting a tool in the state to assist hospitals," she says. Hospitals can use the tool to determine whether they can handle specific adverse events on their own, or whether a case should be referred to the board of nursing. "It's been a very successful pilot."

One of the lessons learned along the way involves leadership engagement. Some of the hospitals in the first collaborative "moved rapidly," while others "barely got out of the starting gate in 18 months. The successful ones were those that had senior leadership engaged from the beginning."

The second lesson was learned after participants in the first collaborative program were asked to go back to their organizations and train their managers. "They had a difficult time providing the training," she says. In the second collaborative, representatives from the center provided the follow-up training, traveling to each hospital and spending up to five hours with key managers, using a training guide by Marx.

Other keys to success were setting achievement milestones and "having the right staff involved," Dr. Koeble says.

The second collaborative has been extremely successful, she notes. "All eight are really moving and are where they should be. We learned from our first program and identified opportunities to make the second collaborative better."

Finding Champions

Becky Miller, MHA, CPHQ, FACHE and executive director of the Missouri Center for Patient Safety in Jefferson City, says her state's journey began after Marx addressed a conference there, attended by about 120 people. Marx received a very enthusiastic response, which resulted in 85% of participants indicating interest in a statewide initiative.

"If you don't have people who are aware of Just Culture and are prepared to act on it, you aren't going to be able to prevent mistakes before they happen. That's something that needs to be drilled down through the whole organization," says Becky Miller, executive director of the Missouri Center for Patient Safety in Jefferson City.

On the advice of the state board of nursing, the center applied for, and got, a patient safety grant of $264,000 that allowed it to organize a collaborative. Initially, a briefing was held for leaders of statewide organizations to educate them about Just Culture and gain support for the collaborative. Soon after, 67 organizations asked to participate, and were accepted into the collaborative. That number included five statewide regulatory agencies, a nursing association, two physicians' offices, a nursing home, a professional school and hospitals.

"We asked each of the organizations to identify a 'champion' within their organization, and then established a leadership team that would work on the project with them," Miller says. "We provided training to the champions and then to their full team. We were also able to provide additional training for organizations wanting to take the next step; 21 received more intensive onsite training for their full executive or management team, or full staff." Approximately 4,000 people in Missouri were trained in Just Culture concepts as a result of the project.

A researcher helped the center modify a survey tool to determine if those participating in the collaborative came away with increased understanding, "and if they implemented that in their organizations."

Miller says the initiative proved successful. "We did see a difference, particularly in organizations that got the additional training. Their leaders seemed to be more aware of what their staff perceptions were regarding Just Culture. We think that opened up leaders' eyes. Those leaders thought their staff members were more mindful of errors and mistakes. They were doing more investigations, even if there wasn't serious harm."

She adds, "Regulators also told us they had a better understanding of the issues providers were dealing with, and they were interested

in integrating these concepts into their own regulatory processes."

Miller, who has a background in health policy, regulations, and risk management in acute care, says Just Culture "really takes the way I tried to work intuitively, and puts a model and some science behind it. If you don't have people who are aware of Just Culture and are prepared to act on it, you aren't going to be able to prevent mistakes before they happen. That's something that needs to be drilled down through the whole organization."

And while that's easier said than done, the CEO and a physician at a few hospitals "sat through an entire day of training. That's the kind of organization that you're really seeing taking the lead in doing this kind of work," she says.

Making Healthcare Safer

Theresa Manley, chair of the California Patient Safety Action Coalition (CAPSAC), says that state's action on Just Culture arose out of two mandatory reporting laws that became effective in July 2007. One was an adverse event reporting mandate; a second piece of legislation introduced an administrative fine for hospitals that failed to report these events in a timely way.

"We decided we wanted to get a group of people together across the continuum of healthcare in California to see how we could make healthcare safer," Manley says. "At the state level, we all agreed that in light of this punitive legislation that was passed, as a healthcare provider community, we saw a real value in looking at the culture in our organizations."

CAPSAC obtained a grant to hold a convening meeting in July 2008, and decided to partner with Marx's company, Outcome Engineering, "in trying to spread the idea of fair and just culture."

Before long, the number of CAPSAC's membership organizations grew from 20 to 60. "There was a feeling of urgency among healthcare organizations on how to become safer. We can do a better job of investigating adverse events and finding out why people make the behavioral choices they do. We thought the Just Culture approach could help."

The coalition began conducting regional trainings across the state for a nominal fee, training more than 900 people, including risk managers and senior leaders, in the Just Culture model. In 2009, the focus turned to investigating adverse events.

CAPSAC is also developing a physician strategy. "We cannot have a successful Just Culture without physician involvement," says Manley. "We're going to work with the California Medical Association and senior physician leaders across the state to help lead this effort."

In addition, CAPSAC is reaching out to the broader community by working with Americans For Quality Healthcare, a national partnership organization, to help identify and engage consumer advocacy groups in its efforts.

"We want to get the patients to sit at the table with us and help us understand how we can influence public perception and, in turn, educate our legislators on principles of

a fair and just culture. We want to do more outreach and influence the provider groups in having one voice about eliminating reckless behavior," Manley says.

As for healthcare professionals, she believes that safe behavior "must become so embedded that it becomes the habit and pattern of every person."

"History will tell you that having a punitive approach will not get you very far with human behavior. It goes to the fundamentals of social psychology. Instead of saying, 'We're going to fine you every time you don't wash your hands,' we need to influence your behavior through the social behavior in organizations by highlighting the inherent risk," Manley says.

"The Just Culture model gets it right because you can't put red rules in places for everything. A social system must be provided so the individual can recognize the inherent risk and make the right behavioral choices, so at the end of the day we can all feel good about the work we're doing."

Dr. Koeble of North Carolina says, "The big thing to realize is that in healthcare in general, nobody wants to do a bad job. In the past, if an error or mistake happened, we generally punished people. That shuts off the information pipeline around the event, and we can't learn from that. Just Culture allows the person to speak up and talk about a mistake. If something happened to them, they're going to be treated fairly. They are responsible for their own actions, they have choices, and they know what's expected of them."

"We can do a better job of .investigating adverse events and finding out why people make the behavioral choices they do. We thought the Just Culture approach could help," says Theresa Manley, chair of the California Patient Safety Action Coalition.

At the same time, if they choose to deviate from acceptable behavior, "there are repercussions that can happen. If someone coaches me to be in a good place, that's a positive thing, and I shouldn't take it personally."

Manley adds, "This is almost like good parenting. As a supervisor, manager or leader, you're trying to influence the choices that people will make when you're not there. Let's make sure that healthcare workers are not reckless or at risk, and that they choose the right things to do. I think that's why Just Culture really has such broad appeal. It speaks to the intelligence and integrity of healthcare providers." PS