



**NATIONAL ACTION ALLIANCE**  
for Patient and Workforce Safety

# **Safety Best Practices of High-Performing Healthcare Systems Related to Safety Culture, Leadership, and Governance**

**NAA National Webinar**  
September 22, 2025

# Housekeeping Instructions

- This webinar will be recorded and available for viewing on the NAA website
- Please use the “Chat” function to engage with us throughout the webinar and to ask questions
- Closed Captioning (CC) is available
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**Thank You for Your Commitment  
to Advance Patient and Workforce Safety!**

# Brief Agenda

Topic	Presenter
<b>Framing and Background</b> <ul style="list-style-type: none"><li>• <b>Identifying High-Performing Health Systems</b></li><li>• <b>Change Packages and the Theory of Change</b></li></ul>	<b>Jenn Schreiber, MSN, MBA, RN–Ripple Effect</b> Principal Program Analyst Best Practices Evaluation Team Member
<b>Safety Culture</b>	<b>Shawn Tittle, MD, MBA–Houston Methodist</b> Senior Vice President and System Chief Quality Officer
<b>Leadership</b>	<b>Donna Sabol, MSN, RN–St. Luke’s University Health Network</b> Senior Vice President and Chief Quality Officer
<b>Governance</b>	<b>Pauline Byom, MBA–Mayo Clinic</b> Vice Chair (Interim), Mayo Clinic Quality
<b>Roundtable Facilitated Discussion</b>	<b>All</b>

# Questions to Run On

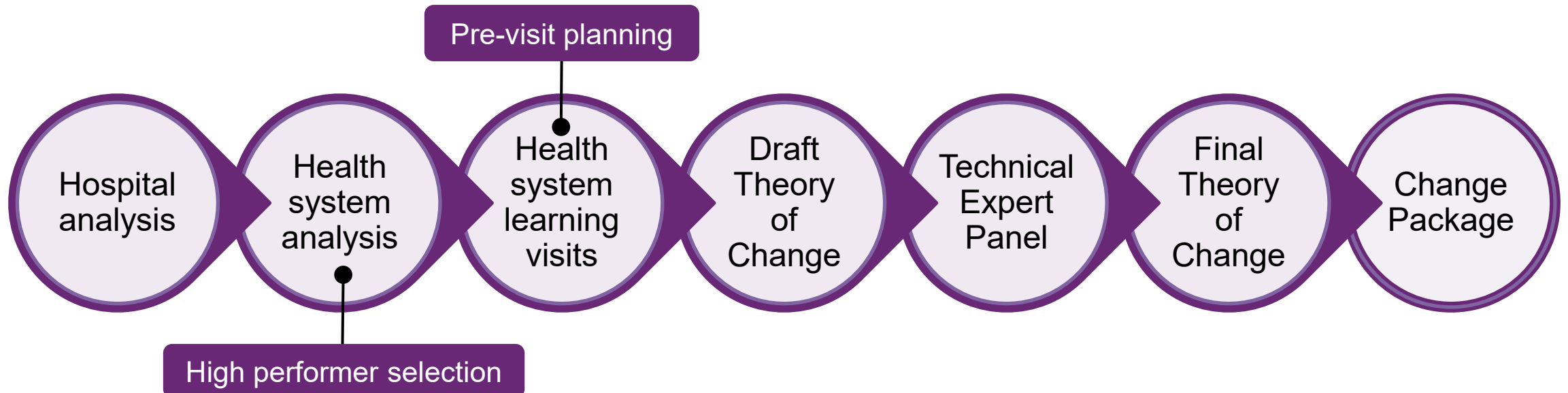
- **Which characteristics of the high-performing health systems resonate most with you?**
- **Which actionable practices could you see your organization implementing?**

# Background

## Premise:

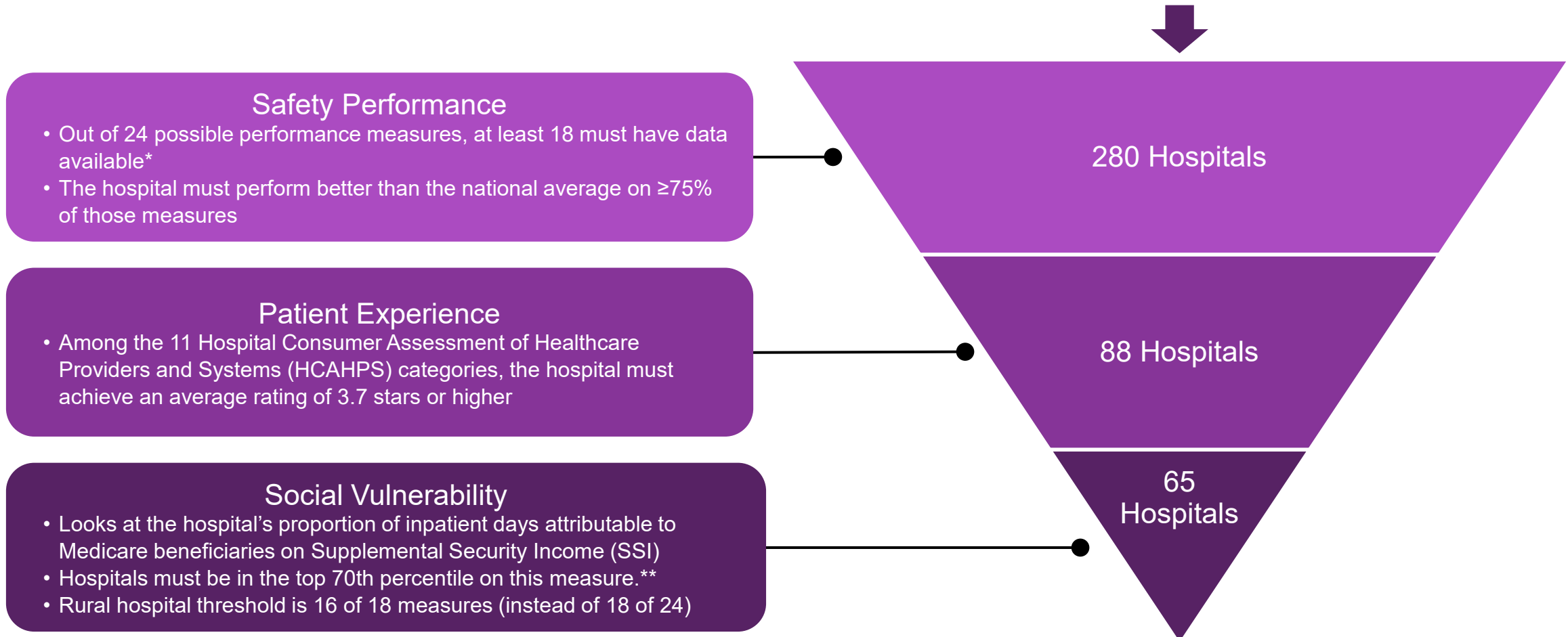
- Top performers on safety and patient experience metrics, adjusted for patient complexity at the population level, would have safety culture, leadership, and governance characteristics and practices that contribute to their results.

## Process:



# Identifying High-Performing Hospitals

Pool of Potential High-Performing Hospitals (n=4791)



- CMS Provider Data Catalog data from Hospital Complications and Deaths and Hospital Healthcare-Associated Infections
- \*\*Hospitals in the lowest 30 percentile (i.e., those serving small numbers of vulnerable patients) were excluded from the candidate list.

# Broad Geographic Reach · Varied Sizes · Rural Presence

**The 65 top-performing hospitals span nearly every region of the country, range widely in size, and include a significant share of rural facilities**



## Geographic Representation

- Hospitals represented in over 29 states
- 9 out of 10 CMS regions represented



## Hospital Size

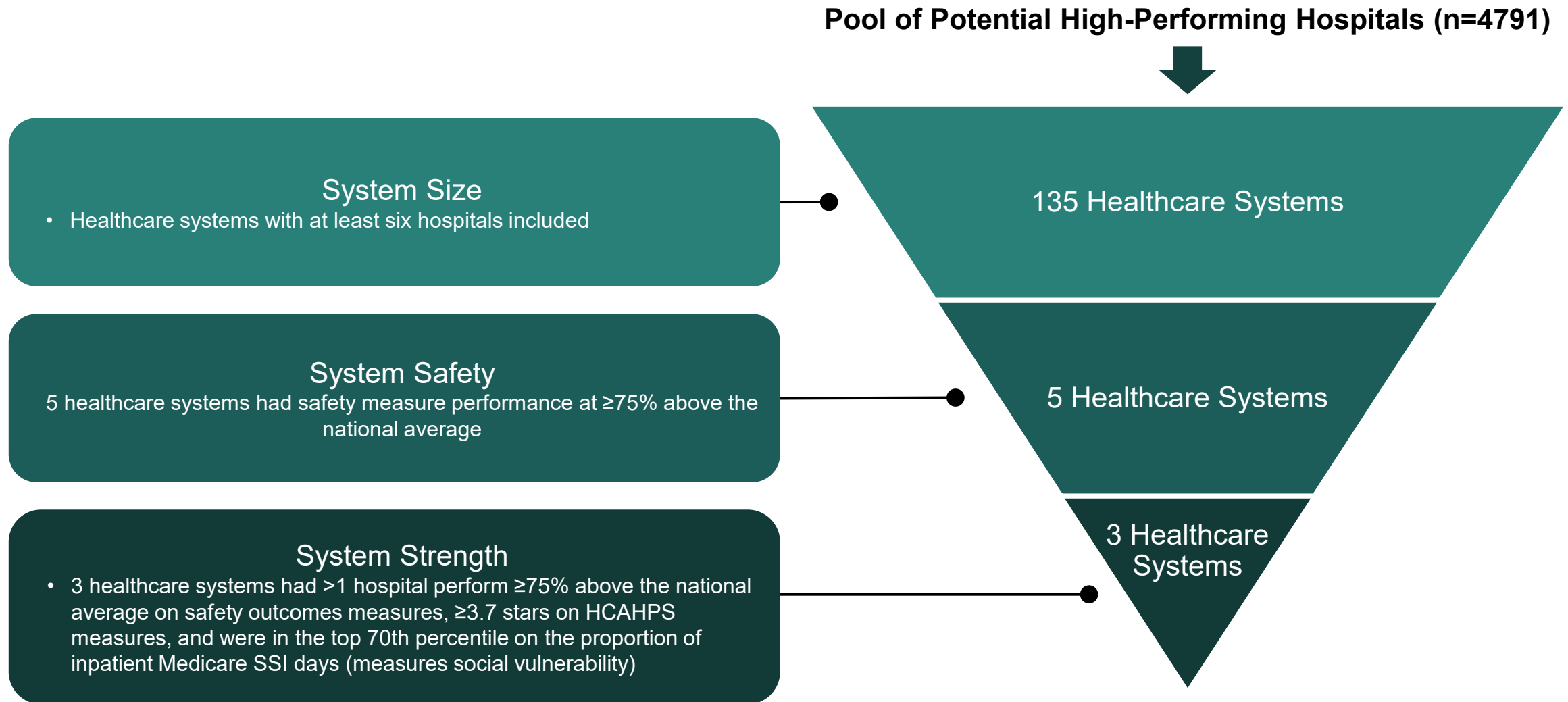
- Bed sizes range from 25–1,157
- Average number of beds = 158
- Median number of beds = 57



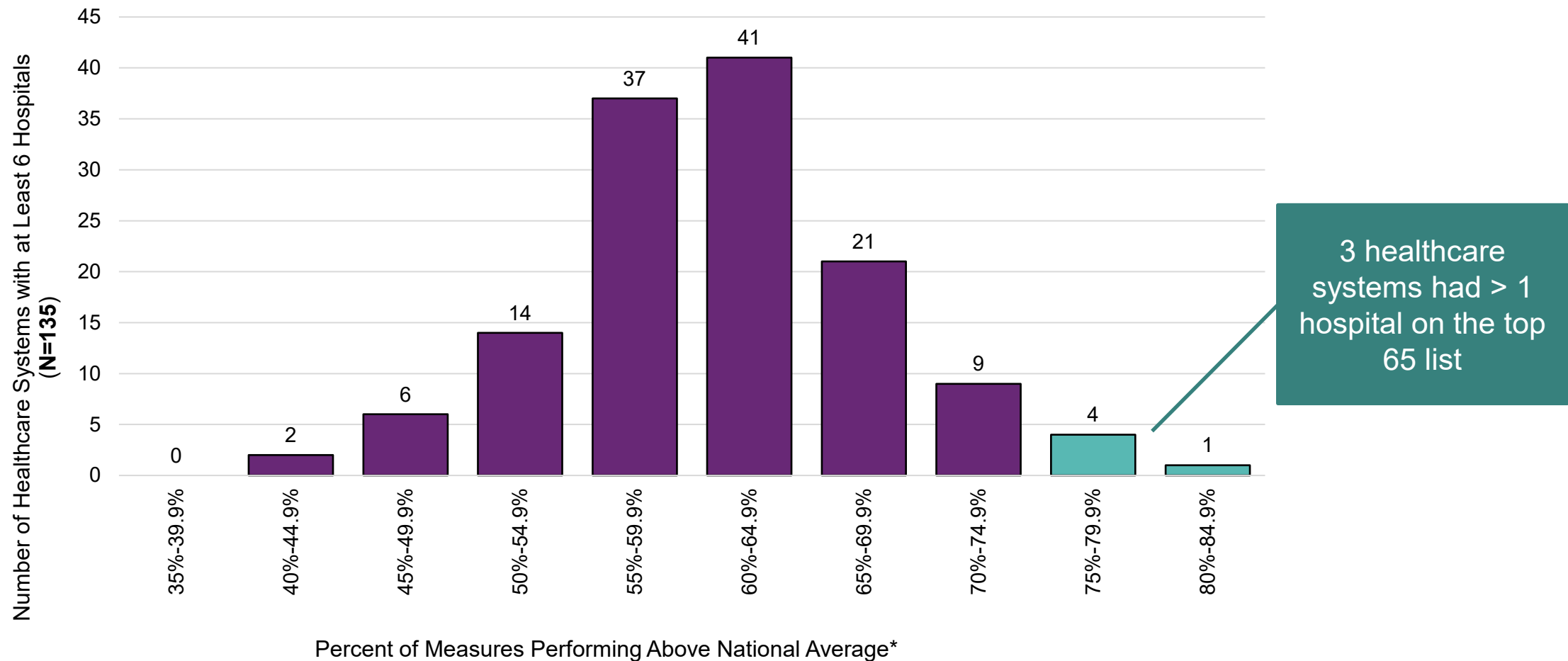
## Rural Representation

- Nearly half (49%) of hospitals represented are in rural areas

# Identifying High-Performing Healthcare Systems



# Healthcare Systems: Percent of Measures Performing Above National Average



\*Based on all available safety outcomes data (CMS Provider Data Catalog) and patient experience data (HCAHPS)

# High Performers Selected for Learning Visits

- **Houston Methodist:** Houston Methodist Hospital (Houston, TX) and Houston Methodist Baytown (Baytown, TX)
- **Mayo Clinic:** Rochester (Rochester, MN) and Eau Claire Hospital (Eau Claire, WI)
- **St. Luke's University Health Network:** Bethlehem Campus (Bethlehem, PA) and Miners Campus (Coaldale, PA)



# Learning Visit Locations

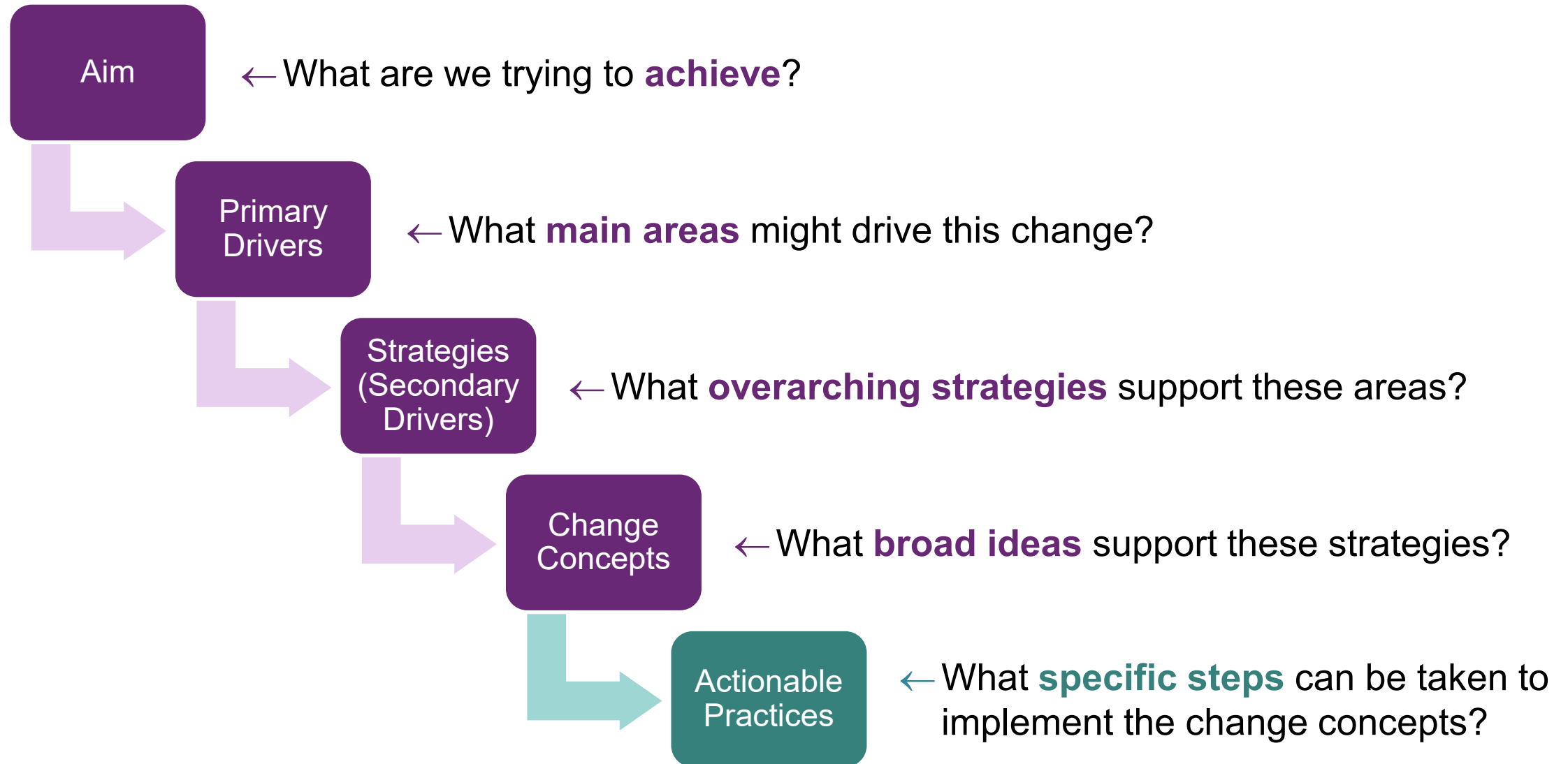


# Change Packages

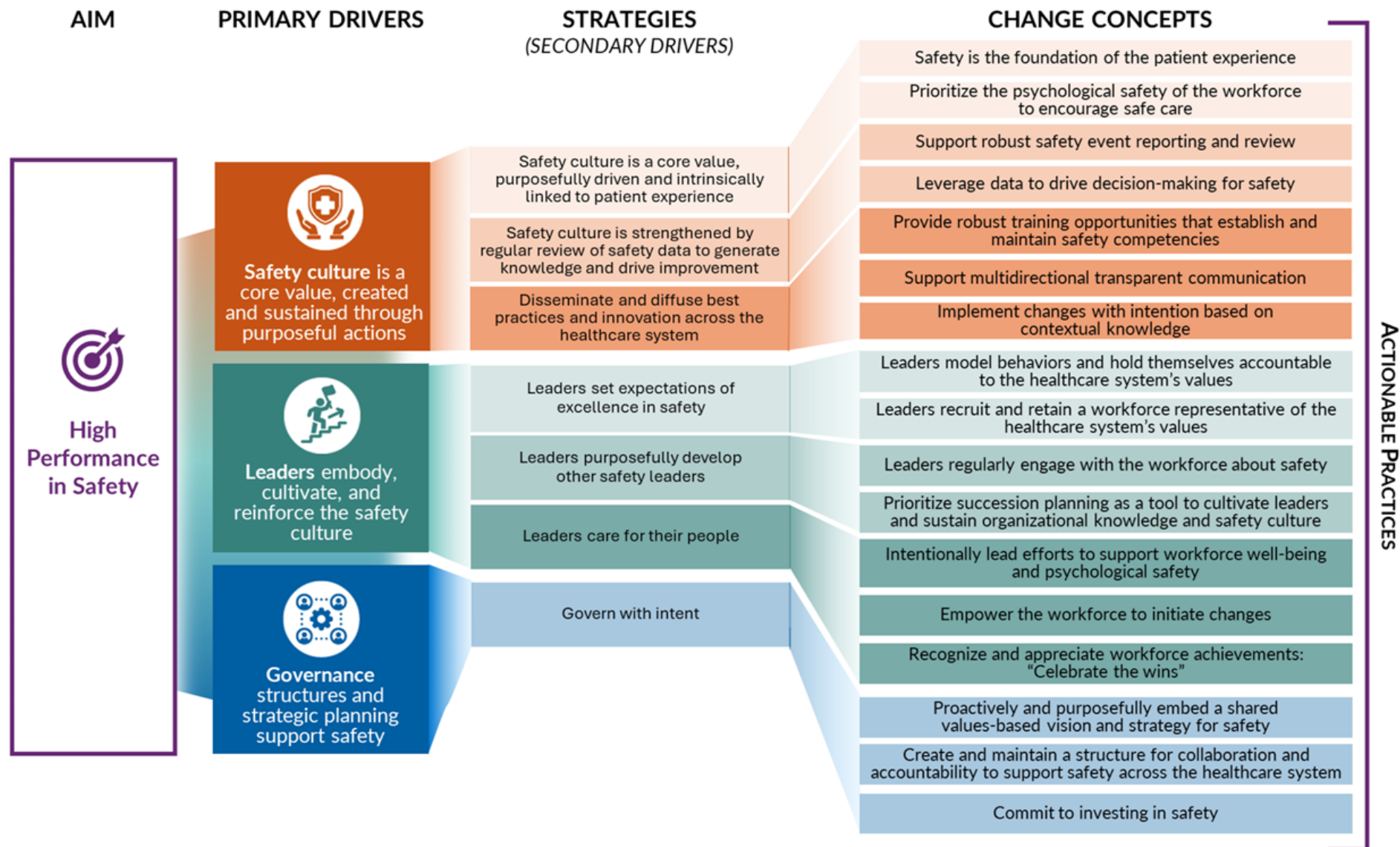
**Change package:** A menu of strategies, change concepts, and actionable practices that anyone can use to improve—built from what is known to be **working well**

Strategies	Change Concepts	Actionable Practices
Overarching big picture categorization	Broad ideas/approaches to change that have been useful in developing specific ideas that lead to improvement	Specific steps that can be taken to implement the change concepts

# Developing a Theory of Change



# Overview of the Theory of Change



# Safety Culture

Change Concepts	Actionable Practice Examples
Safety is the foundation of the patient experience	Conduct multidisciplinary rounds and bedside shift reports to coordinate care team messaging to the patient and family.
Prioritize the psychological safety of the workforce to encourage safe care	Use a systematic event review framework that focuses on process optimization over personal fault and balances personal and system accountability.
Support robust safety event reporting and review	Establish a user-friendly system for reporting all safety events. Use positive reinforcement to encourage reporting, such as system-level recognition, and establish a structure to close the loop on actions that occurred as a result of reporting.
Leverage data to drive decision making for safety	Benchmark data internally and externally and establish standard metrics, definitions, and data sources that are shared across the healthcare system.
Provide robust training opportunities that establish and maintain safety competencies	Embed the healthcare system's values, including safety, in new employee orientation and reinforce through values-based training.
Support multidirectional transparent communication	Conduct structured daily meetings that occur across multiple levels of leaders within the healthcare system to facilitate communication from the unit to senior system leaders (i.e., tiered huddles).

# Leadership

Change Concepts	Actionable Practice Examples
Leaders model behaviors and hold themselves accountable to the healthcare system's values	Make it acceptable for the workforce to fail and learn from failures—Fail forward.
Leaders recruit and retain a workforce representative of the healthcare system's values	Establish an extensive vetting process for new leaders with multidisciplinary and multilevel interviews to ensure alignment with the safety culture.
Leaders regularly engage with the workforce about safety	Require and support regularly scheduled leader rounding with the workforce and patients focused on problem-solving, patient safety concerns, real-time reporting, and accountability.
Prioritize succession planning as a tool to cultivate leaders and sustain organizational knowledge and safety culture	Intentionally develop current and future leaders through mentorship, coaching, and training with succession planning in mind.
Intentionally lead efforts to support workforce well-being and psychological safety	Proactively take leadership accountability to identify and alleviate causes of workforce burnout at the local level (e.g., respect for time, staffing, and administrative burden).
Empower the workforce to initiate changes	Empower the workforce with the autonomy and resources to resolve safety concerns for patients and staff.
Recognize and appreciate workforce achievements: "Celebrate the wins"	Decrease barriers and burdens for the workforce to complete their work.

# Governance

Change Concepts	Actionable Practice Examples
Proactively and purposefully embed a shared values-based vision and strategy for safety	Commit to safety, quality, and patient experience as core values (i.e., Safety is a Core Value)—The values drive the mission and vision across the entire healthcare system.
Create and maintain a structure for collaboration and accountability to support safety across the healthcare system	Employ a mechanism to hold the workforce accountable for safety outcomes and for maintaining the culture of safety, e.g., by incorporating expectations related to physical and psychological safety into position descriptions and rewarding good performance.
Commit to investing in safety	Recognize that safety, quality, and patient experience are competitive business advantages and value harm avoidance as an independent ROI worthy of prioritization.

# Speaker Welcome



**Shawn Tittle, MD, MBA**

Senior Vice President and System Chief  
Quality Officer, Houston Methodist



**Donna Sabol, MSN, RN, CPHQ**

Senior Vice President and Chief Quality  
Officer, St. Luke's University Health  
Network



**Pauline Byom, MBA, CPHQ, FHIMSS**

Vice Chair (Interim), Mayo Clinic Quality  
Mayo Clinic

# **Safety Best Practices of High Performing Healthcare Systems Related to Safety Culture, Leadership and Governance**

**Shawn Tittle, MD, MBA**

**Senior Vice President and System Chief Quality Officer  
Houston Methodist**

**September 22, 2025**

# Culture of Safety – Implementation Concepts

<p><b>Approach Objectively</b></p>	<p><b>ACT</b></p>	<p><b>Data Driven</b></p>	<p><b>Stakeholders</b></p>	<p><b>Listen, Listen &amp; Listen</b></p>
<ul style="list-style-type: none"> <li>• Observations with front line staff</li> <li>• Walk in their shoes</li> <li>• Gather evidence</li> <li>• Never punitive</li> </ul>	<ul style="list-style-type: none"> <li>• Accountability</li> <li>• Collaboration</li> <li>• Transparency</li> </ul>	<ul style="list-style-type: none"> <li>• Before and after</li> <li>• What is the ‘REAL’ work being done?</li> <li>• Metrics are consequential, fix the process</li> </ul>	<ul style="list-style-type: none"> <li>• Frontline staff know the issues and what the solutions are</li> <li>• Engage ALL stakeholders</li> <li>• Engage detractors</li> </ul>	<ul style="list-style-type: none"> <li>• Tell me your story</li> <li>• Translate to operational solutions</li> <li>• How does work of one group affect another group and the system?</li> </ul>
<p><b>Acceptance of Change</b></p>	<p><b>Frameworks</b></p>	<p><b>Standardization</b></p>	<p><b>Technology</b></p>	<p><b>Failure</b></p>
<ul style="list-style-type: none"> <li>• Different needs per stakeholder</li> <li>• In healthcare, change management is critical</li> </ul>	<ul style="list-style-type: none"> <li>• Create frameworks not processes</li> <li>• Allow for local customization</li> <li>• Evidence-based and intentional design</li> </ul>	<ul style="list-style-type: none"> <li>• Standardization does not mean the same</li> <li>• Superior customized care for each patient and family</li> </ul>	<ul style="list-style-type: none"> <li>• High-touch, high-tech</li> <li>• Choose the correct technology</li> <li>• Use existing tools in a different way</li> </ul>	<ul style="list-style-type: none"> <li>• Do not be afraid to fail</li> <li>• “Fail early. Fail often. Fail forward.”</li> <li>• Initial process is only about 80% correct</li> </ul>

# Continuum of Care – Houston Methodist Baytown Hospital

## Emergency Department Model

- Three Stages:
  - Arrival & Check-in
  - Assessment & Testing
  - Treatment & Disposition
- Staffing Models by Arrivals
- SBAR Reports
- New EVS and Transport Coverage
- ED Admissions Hospitalist Team
- Multiple Visit Patient (MVP) Program



## Hospitalist Service & Multidisciplinary Teams

- In-Person Rounding
- Cohorting by Diagnosis Group
- Data Driven Protocols
- Hospitalists and Specialist Huddles
- Patient Experience Training
- Online Scheduling Platform
- Case Management and Social Work Embedded in Unit



## Patient Discharge

- Epic Discharge Module for CMSW
- RN Discharge Process
- New EVS and Transport Coverage

# ONE HOUSTON METHODIST.

One Unparalleled  
Future.



## **Focus on Leadership**

**Donna Sabol, MSN, CPHQ  
Senior VP, Chief Quality Officer**



# Leadership – Anesthesia Department Succession

## **Purposefully Build Safety Leaders**

Vice Chair Model  
OD Support

How to Coach & Mentor  
EI, Crucial Conversations  
360° Evaluation, Leadership Inventories, MBTI

## **Expect Excellence in Patient Safety**

Fail & Learn

AKI Project  
Safety Net  
Deterioration Index

Cultural Fit

Psychological Safety  
A Team Sport

Finger on the Pulse

COS Survey—9 of 11 Top Quartile  
*Forbes* Best in State – # 1  
*USA Today* Top Workplace – #1 in US, only one in PA

## **Celebrate Successes**

Enjoy the Ride

Network Quality Awards  
Healthy Competition



Quality



# Mayo Clinic

## Mission

*To inspire hope and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education, and research.*

## Our Primary Value

*The needs of the patient come first*

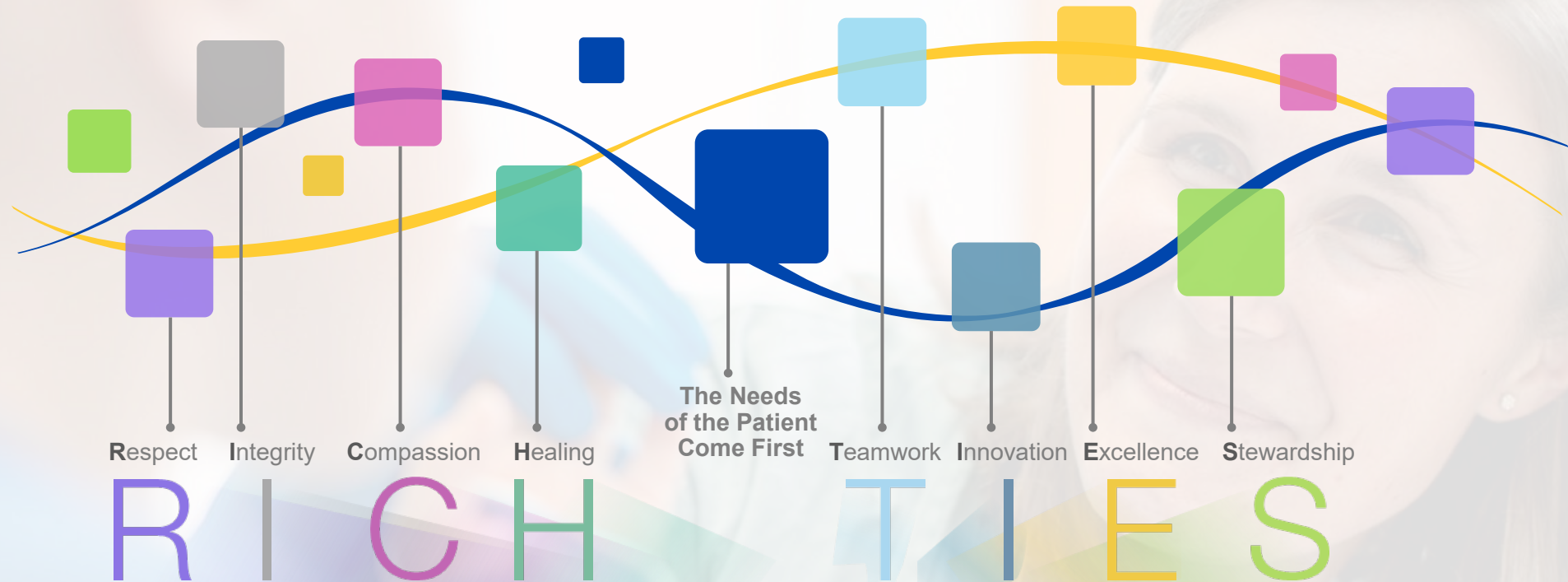
## Mayo Clinic Model of Care

- Salaried Physicians
- Unhurried exams
- Team-based approach

# Mayo Clinic Values

*"The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge, union of forces is necessary." –William J. Mayo  
Commencement Address, Rush Medical College, University of Chicago, June 15, 1910*

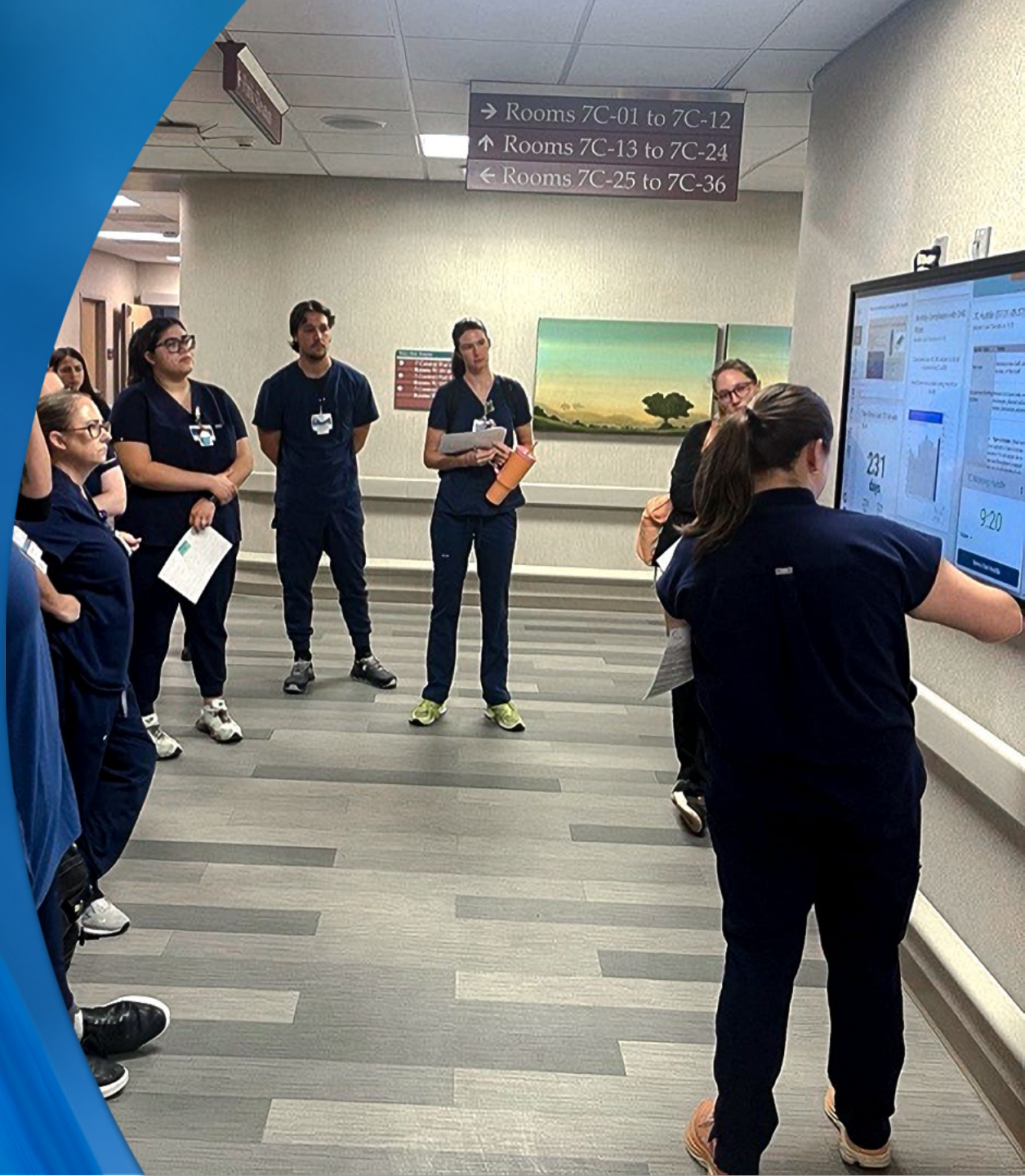
## Mayo Clinic Values



# 2030 Quality Trinity of Strategic Imperatives



# Tiered Huddles Using Digital Visual Management Boards





# Questions & Answers

# Share With Us!

## Based on what you have learned today:

- How will you use the change package to improve safety within your organization?
- Which actionable practices discussed could you see your organization implementing?

**\*Please submit your response in the chat**

Thank You!

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