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National Action Alliance for Patient and Workforce Safety

Best Practices to Strengthen Safety Culture, Leadership, and Governance Change Package: Technical Report

Final

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- **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)

AHRQ would also like to express gratitude to the technical expert panel participants who contributed to this work, including representatives from the high-performing healthcare systems and many thought leaders from the national patient safety community. In addition, AHRQ would like to acknowledge the larger patient safety community for its continued dedication to improving patient and workforce safety.

Introduction

Background

The Agency for Healthcare Research and Quality (AHRQ) established the National Action Alliance for Patient and Workforce Safety (National Action Alliance) as a public-private partnership. This includes federal agencies and private stakeholders, such as healthcare systems, patient safety advocates, professional societies, and payers. The collective partnership ensures alignment and progress on patient and workforce safety to reach the stated goal of a 50 percent reduction in patient and healthcare workforce harm by 2026.

The National Action Alliance builds on the work of the National Steering Committee (NSC) for Patient Safety, which in 2020 released the National Action Plan (NAP) via the report *Safer Together: A National Action Plan to Advance Patient Safety*.[1] The NAP is the result of the contributions and insights of 27 leading organizations that joined together as the NSC to develop a framework for reducing harm to patients and healthcare workers. The NAP presents 17 recommendations that are organized into four foundational areas: (1) culture, leadership, and governance; (2) patient and family engagement; (3) workforce safety; and (4) learning system. An accompanying implementation resource guide presents key influencers, implementation tactics, and case studies for each foundational area.

To support healthcare systems in their efforts to strengthen their safety culture, leadership, and governance – the bedrock of the NAP — AHRQ funded a review of healthcare systems that are high performers in safety, to identify their best practices in safety culture, leadership, and governance. The goals of this effort included:

- Identifying best practices in safety culture, leadership, and governance that demonstrate results in achieving patient and healthcare workforce safety.
- Spreading the best practices by developing a change package for use by healthcare systems nationwide that are seeking to improve safety.

To achieve these goals, AHRQ, through its contractor Ripple Effect Communications, Inc. and its partner the American Institutes for Research (collectively, the contractor team), conducted the following activities, grounded in quality improvement:

- Leveraged publicly available data, as well as input from subject matter experts, to identify healthcare systems that demonstrated high performance in safety across multiple hospitals within their system.
- Conducted learning visits with the high-performing systems to identify best practices in safety culture, leadership, and governance that drive patient and workforce safety.

[1] National Steering Committee for Patient Safety. *Safer Together: A National Action Plan to Advance Patient Safety.* Boston, MA: Institute for Healthcare Improvement; 2020.

- Engaged a technical expert panel (TEP) to provide insights and input, leading to the development of a change package for national dissemination.

In addition to supporting healthcare systems in achieving success in reducing patient and workforce harm, this work seeks to support healthcare systems' success in achieving national benchmarks. These include, for example, the Centers for Medicare & Medicaid Services (CMS) Patient Safety Structural Measure and the Leapfrog Hospital Safety Grade, both of which require hospitals to demonstrate strong safety culture, leadership, and governance practices.

Overview of Document

The sections that follow present the approaches used to (1) identify high-performing healthcare systems, (2) glean best practices in safety culture, leadership, and governance, and (3) engage with the TEP to result in the *Best Practices to Strengthen Safety Culture, Leadership, and Governance Change Package*. This report also provides a more detailed description of the change concepts and actionable practices that contribute to improved safety outcomes for healthcare systems. The appendices provide supporting materials, such as the measures used to identify high performers, as well as a copy of the *Best Practices to Strengthen Safety Culture, Leadership, and Governance Change Package*.

High-Performing Healthcare System Identification

Using quantitative and qualitative data, a multi-phased analytic approach was designed to identify high-performing healthcare systems. The approach was based on the premise that healthcare systems with high performance in safety outcomes and patient experience scores across multiple hospitals in their system—while adjusting for patient complexity at the population level—would have safety culture, leadership, and governance characteristics and practices that contribute to their results.

Analyses focused on publicly available patient safety and experience measures to identify hospitals and healthcare systems with strong performance in safety culture, leadership, and governance. An exploration of performance over time was not conducted. Therefore, for the purposes of this effort, "high-performing" refers to performance associated with the measures and data sources presented in Appendix A for the specific time period examined. The analytic process used for high performer identification is discussed below.

Hospital Analysis

Analysis began with an exploration of high-performing hospitals. The analysis used publicly available safety data from the CMS Provider Data Catalog to assess performance across a set of 24 safety outcome measures, including infections (e.g., rates of central line associated blood stream infections, surgical site infections), complications (e.g., rates of post-operative sepsis, complications from hip or knee replacements), and mortality (e.g., death rates for specific diagnoses) data. The measures consisted of 18 measures from the Provider Data Catalog

Complications and Deaths files[2] and six measures from the Healthcare-Associated Infections file. For each of the 4,791 hospitals in the files, the percentage of measures for which performance was better than the national average was calculated.[3] This resulted in the identification of 1,262 hospitals for which performance on 75 percent or more of their measures was better than the national average. The criteria were further refined to ensure that all hospitals in the list had data for at least 18 of the 24 measures (i.e., 75 percent of the measures). With this criterion, hospitals with limited services were excluded, such as children's hospitals and most critical access hospitals, because they do not report on all measures. Applying this criterion reduced the list to 280 hospitals.

The next step integrated the CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data from the CMS Provider Data Catalog into the review. HCAHPS data apply a star rating on a scale of 1-5 for 11 categories. For the purposes of this review, high-performing hospitals were expected to have strong patient experience results across categories. Therefore, hospitals with an average of 3.7 stars or higher across the 11 patient experience categories were retained in the list, further reducing the list to 88 candidate hospitals.

It was important to ensure that the patient population served at the candidate hospitals was similar in terms of case mix complexity. For example, hospitals that serve patient populations with multiple comorbidities may experience more challenges resulting in longer inpatient stays that require more clinical support. Therefore, to adjust for patient population, the analysis incorporated the following variable from the Medicaid Disproportionate Share Hospital Payments Annual Exception List: the percentile ranking of the percentage of Medicare Supplemental Security Income days by total inpatient days. Hospitals in the lowest 30th percentile (i.e., those serving small numbers of vulnerable patients) were excluded from the candidate list, reducing the list to 51 candidate hospitals.

To ensure the appropriate representation of rural hospitals among the candidate list, the criteria were further revised for any hospital designated as rural.[4] Specifically, instead of requiring rural hospitals to have data for at least 18 of the 24 CMS Provider Data Catalog measures used in the analysis, rural hospitals needed data for at least 16 of the 24 outcomes measures. This change resulted in the addition of 14 rural hospitals to the candidate list, expanding the list to 65 high-performing hospitals. Among the list of 65 hospitals, 29 states were represented. The hospitals ranged in size from 25 to 1,157 licensed beds, and 32 hospitals were designated as rural hospitals.

As an additional step, the CMS Overall Star Rating provided in the CMS Provider Data Catalog (i.e., Hospital General Information data file) and the Leapfrog Hospital Safety Grade were reviewed for each of the 65 hospitals on the list. Eight hospitals were too small to have a CMS Star Rating.

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[2] As presented in Appendix A, data from two different Complications and Deaths files were accessed and used.
[3] National averages for the 18 measures from the Provider Data Catalog Complications and Deaths files are included in the publicly available data file. National average for the six measures from the Healthcare Associated Infections file were calculated by summing all reported infections in the file for each type of infection and then dividing by the number of eligible cases to calculate a national standardized infection ratio for each infection type.
[4] As described by the Center for Healthcare Quality and Payment Reform, a hospital is classified as "rural" in the data if it is located in a geographic area that is classified as rural by the Health Resources and Services Administration (HRSA). Further details about this definition can be found at the link above.

Among those that had a rating, all but four hospitals earned 4 or 5 stars. Among hospitals for which a Leapfrog Hospital Safety Grade was available, the majority of grades were As and Bs. Eleven hospitals had a Leapfrog grade of C; however, 9 of the 11 were rural hospitals, and all 11 were very small hospitals. None of the hospitals with a grade of C were recommended for a learning visit.

Finally, the AHRQ Compendium of U.S. Health Systems enabled the identification of healthcare systems to which each hospital belonged. This step supported the subsequent efforts, described below, to identify high-performing healthcare systems.

Healthcare System Analysis

To identify high-performing healthcare systems, the list of all 4,791 hospitals was again reviewed to explore whether there were any healthcare systems that demonstrated strong performance across all the hospitals in their system. This began by filtering the list to include healthcare systems that included at least six hospitals, yielding 135 healthcare systems for examination. Next, using data from the CMS Provider Data Catalog, the following were summed for each system: (1) the total number of measures with performance above the national average for each hospital and (2) the total number of measures that applied to each hospital. The criterion applied in the hospital analysis that hospitals must have data for at least 18 of the 24 measures was not applied at the system level to facilitate a more complete view of a system's performance.

Among the 135 systems, five performed better than the national average on at least 75 percent of their measures across all their hospitals. Three of the five systems (Houston Methodist, Mayo Clinic, and St. Luke's University Health Network) had more than one hospital on the list of 65 high-performing hospitals and demonstrated strong HCAHPS scores across their hospitals (Exhibit 1).

Exhibit 1. Healthcare Systems with Overall High Performance

Healthcare System	Number of Hospitals in System	Number of Hospitals in List of Top 65 Hospital Performers	Number of Measures Performing Better than National Average	Total Measures that Apply to the Hospitals	Percent of Measures Performing Better than National Average
St. Luke's University Health Network	9	5	138	169	81.7%
Houston Methodist	7	3	129	164	78.7%
Mayo Clinic	21*	3	206	270	76.3%

*Analyses were based on the 21 acute care hospitals listed in the AHRQ Compendium of U.S. Health Systems (2022) as being part of the Mayo Clinic. As of the time of this report, the Mayo Clinic recognizes 19 hospitals as part of its enterprise.

Additional information about the three systems is presented below:

- **Houston Methodist:** This system includes seven hospitals in and around Houston, Texas (West South Central region[5]). Three of their seven hospitals were included in the list of 65 high-performing hospitals, and all seven hospitals demonstrated strong performance. The three hospitals in the list of 65 high performers range in size from 178 to 292 beds. Their flagship hospital is a 966-bed facility. All seven hospitals received a Leapfrog Hospital Safety Grade of A, and six hospitals received a CMS Star Rating of 5.

- **Mayo Clinic:** This system includes 19 hospitals, several of which are located in the Midwest region. Three of their hospitals were included in the list of 65 high-performing hospitals, including the flagship hospital in Rochester, Minnesota (1,157 beds) and the Eau Claire Hospital in Eau Claire, Wisconsin (186 beds). All hospitals for which a Leapfrog Grade was available had a grade of A. All but one of the hospitals with an available CMS Star Rating earned a rating of 4 or 5.

- **St. Luke's University Health Network:** This network consists of nine hospitals in central-eastern Pennsylvania and New Jersey (Middle Atlantic region). Among their hospitals, five were included in the list of 65 high-performing hospitals, and all nine demonstrated strong performance. The five hospitals in the list of top 65 ranged in size from 40 to 98 beds, with two designated as rural hospitals. All nine hospitals received a Leapfrog grade of A, and eight hospitals received a CMS Star Rating of 5.

Following the identification of the three systems, two hospitals within each system were identified as priority candidates for the learning visits, as listed alphabetically by system in Exhibit 2.

Exhibit 2. Priority Hospital Candidates for Learning Visits

Healthcare System / Hospital	State	Percent of Measures Better than National Average Performance	Average Number of Stars in 11 HCAHPS Categories	Rural?
Houston Methodist / Houston Methodist Baytown Hospital	TX	78.3%	3.91	No
Houston Methodist / Houston Methodist Hospital*	TX	83.3%	3.64**	No
Mayo Clinic / Mayo Clinic Eau Claire Hospital	WI	79.2%	4.27	No

[5] Regions listed are derived from the United States Census Bureau.

Healthcare System / Hospital	State	Percent of Measures Better than National Average Performance	Average Number of Stars in 11 HCAHPS Categories	Rural?
Mayo Clinic / Mayo Clinic Hospital Rochester*	MN	75.0%	4.36	No
St. Luke's University Health Network / St. Luke's Hospital Bethlehem*	PA	87.5%	3.45**	No
St. Luke's University Health Network / St. Luke's Miners Memorial Hospital	PA	81.3%	4.00	Yes

*Flagship hospital for the respective healthcare system.

**Hospital did not meet the HCAHPS score criteria for the list of top 65 high-performing hospitals. However, the team included this hospital as a priority due to it serving as the flagship hospital for the respective high-performing healthcare system.

As a final step in identifying high-performing hospitals and healthcare systems, AHRQ gathered insights from national organizations with knowledge of high-performing systems. This provided final confirmation that if the government expended resources to review the practices of the identified systems, the findings would be consistent with what the outcomes and experience data uncovered.

Learning Visits

Onsite learning visits with hospitals within each of the high-performing healthcare systems offered an opportunity to engage with leaders and the workforce and observe processes that demonstrated the operationalization of each system's safety culture, leadership, and governance. The sections that follow describe the initial planning and pre-work with each system, the approach to the onsite visit, and the findings.

Pre-Visit Planning

Leaders from all three high-performing systems accepted an invitation to participate in the best practices review. The system leaders provided pre-visit information such as organizational charts, mission statements, safety goals, and organizational safety outcomes data to provide pre-visit insights into the healthcare system and its hospitals. In addition, each system identified leaders to participate in pre-visit virtual meetings and provide preliminary insights about drivers of their system's success with safety. Participants in these pre-visit discussions varied by healthcare system and included, for example, quality leaders, administrative leaders, and service line leaders. The pre-visit activities also facilitated agenda planning for the learning visit by serving as a source of recommendations about specific individuals with whom to engage while onsite and specific processes (e.g., huddles, rounding, safety meetings) that would exemplify the system's safety culture, leadership, and governance.

Learning Visit Approach

The learning visits occurred between May and July 2025 (Exhibit 3) and included four members of the contractor team with experience identifying best practices in healthcare settings. The learning visit team included individuals with clinical expertise, experience working in and leading healthcare organizations, and expertise in areas such as safety culture, quality improvement, patient safety, and process improvement.

Each healthcare system led the development of its respective visit agenda, which included planning for one day at the respective system's flagship hospital and one day at a smaller hospital within the system. Additional common elements across visit agendas included opportunities to observe safety huddles and rounding, as well as time to engage with hospital leaders and the workforce one-on-one or in small groups. While engaging leaders and the workforce, an appreciative inquiry approach focused on open-ended interactions to glean insights into what practices contribute to the system's safety outcomes.

At the end of each two-day learning visit, the workforce and leaders from the system who participated in aspects of the visit were assembled for a debrief session, which lasted between one to two hours. The session focused on themes and specific example practices gathered from the activities and appreciative inquiry interactions that occurred during the planning process and while onsite that demonstrated the organization's safety culture, leadership, and governance. Leaders from all three high-performing systems were invited to participate in each debrief to share their reactions and to promote cross-system learning. In addition, AHRQ identified a small number of private organizations to attend the debrief to offer insights by drawing on their national-level experience with patient and workforce safety.

Exhibit 3. Learning Visit Locations and Dates Visited

Healthcare System / Hospital	City, State	Learning Visit Date
St. Luke's University Health Network / St. Luke's Hospital Bethlehem*	Bethlehem, PA	May 13, 2025
St. Luke's University Health Network / St. Luke's Miners Memorial Hospital	Coaldale, PA	May 14, 2025
Houston Methodist / Houston Methodist Hospital*	Houston, TX	June 9, 2025
Houston Methodist / Houston Methodist Baytown Hospital	Baytown, TX	June 10, 2025
Mayo Clinic / Mayo Clinic Eau Claire Hospital	Eau Claire, WI	July 7, 2025
Mayo Clinic / Mayo Clinic Hospital Rochester*	Rochester, MN	July 8, 2025

*Flagship hospital for the respective healthcare system.

Learning Visit Findings

The themes and example practices that were presented to each system during the debrief sessions were based on the information shared and practices observed during the learning visits. These served as the starting point for documenting cross-system themes, practices, and detailed findings. Candidate strategies, change concepts, and actionable practices that were based on information obtained through the pre-visit activities and learning visits were documented and organized by safety culture, leadership, and governance. An iterative process to aggregate and refine the findings yielded a preliminary theory of change, which provided a basis for the change package and a starting point for the TEP members to review, refine, and expand upon through their work at the TEP convening, discussed below.

Technical Expert Panel Convening

A two-day TEP meeting was held in July 2025 in Rockville, Maryland. The purpose of the meeting was to (1) review and refine the theory of change based on the practices observed during the learning visits, and (2) agree upon common language for the change package. In addition to representatives from the three high-performing healthcare systems, the TEP included representatives from federal agencies responsible for programs that include healthcare safety and from private organizations that are dedicated to improving patient and workforce safety. These attendees supported the TEP members by applying their broad knowledge of safety initiatives and resources and ensuring that the change package was understandable and relatable for anyone working in safety. TEP meeting attendees are presented in Appendix B.

The TEP meeting began with an overview of the National Action Alliance goals and efforts to identify best practices in safety culture, leadership, and governance leading up to the TEP meeting. AHRQ and the learning visit team discussed the purpose of the change package and presented the preliminary theory of change, based on what was gleaned from the learning visits to the three high-performing systems. The meeting focused on a series of facilitated breakout sessions that enabled small group discussion followed by report-outs to all meeting attendees. The breakout sessions included discussions focused on refining the theory of change, clarifying and recommending additional actionable practices, and sharing additional real-world stories from the three systems that exemplified the strategies, change concepts, and actionable practices in the theory of change. The second day included a session during which the TEP members ranked the top three actionable practices in each strategy[6] that they would recommend as a starting point for systems that are early in their safety improvement journey or seeking to revise their existing safety programs.

Using feedback from the TEP members and other attendees, additional refinements were made to the theory of change, resulting in a final set of strategies, change concepts, and actionable practices.

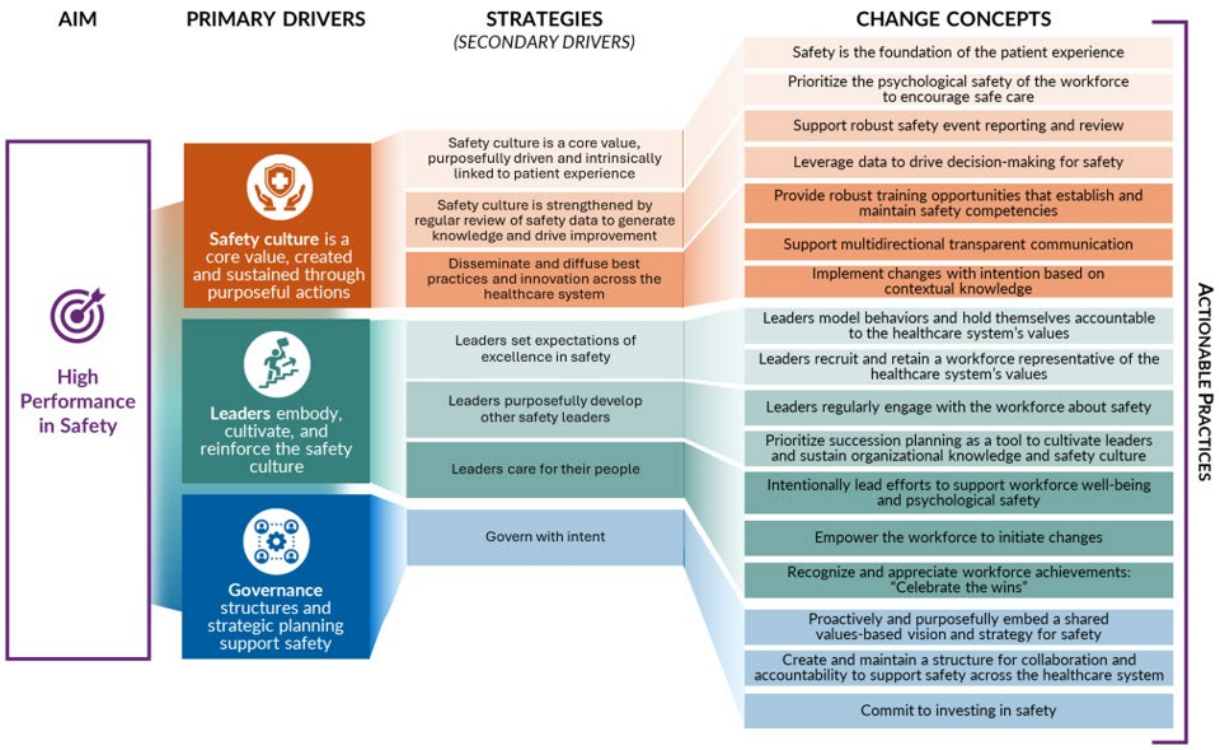
[6] Due to the volume of actionable practices associated with some change concepts, ranking occurred at the change concept level, rather than the strategy level.

Best Practices to Strengthen Safety Culture, Leadership, and Governance Change Package

Based on the final framework, the change package presents healthcare systems with a set of strategies, change concepts, and actionable practices that are organized into three **primary drivers** that address safety culture, leadership, and governance. These primary drivers are the observed key contributors or influencers that drive improvement towards system-level top safety performance (Exhibit 4).

Strategies enable the categorization of higher-level themes within each of the primary drivers. **Change concepts** provide broad ideas or approaches that have been demonstrated to be impactful in leading to improvements. A description of each change concept is presented in the sections that follow, as well as in the complete change package in Appendix C. For each change concept, specific **actionable practices** provide healthcare systems with steps to implement to achieve improvements in safety.

Exhibit 4. Theory of Change



Within the change package, some actionable practices are presented in bold font. These represent actions the high-performing healthcare systems identified through a ranking exercise during the TEP meeting as foundational to their success. Healthcare systems that are beginning their safety improvement journey or are working to revamp their safety programs may wish to prioritize these actions.

The sections that follow are organized according to the following three primary drivers and their associated strategies:

1. Safety culture is a core value, created and sustained through purposeful actions.
2. Leaders embody, cultivate, and reinforce the safety culture.
3. Governance structures and strategic planning support safety.

For each strategy, the practices observed at the high-performing healthcare systems are discussed as they relate to the relevant change concepts. In addition, vignettes are provided to further illustrate implementation through the experiences of the three high-performing healthcare systems.

Primary Driver: Safety Culture is a Core Value, Created and Sustained Through Purposeful Actions

This primary driver focuses on how a system-level culture of safety is established and maintained. Three strategies gleaned from the high-performing systems influence this driver:

1. **Safety culture is a core value, purposefully driven and intrinsically linked to patient experience.**
2. **Safety culture is strengthened by regular review of safety data to generate knowledge and drive improvement.**
3. **Disseminate and diffuse best practices and innovation across the healthcare system**.

Strategy: Safety Culture is a Core Value, Purposefully Driven and Intrinsically Linked to Patient Experience

Change Concept: Safety is the Foundation of the Patient Experience

Safety Culture

High performers view safety as a key part of the patient experience. Patients and their loved ones are an essential part of the care team, and their feedback is incorporated into the design of safety processes and interventions.

In alignment with their mission, vision, and values, high-performing systems ground their safety goals, processes, and procedures in the patient experience. The deep commitment to the patient experience was observed systemwide, including through the decision-making of system-level leaders and the patient care policies, processes, and procedures that the workforce implements. These systems set an expectation that patients, family members, and caregivers contribute to their system-level safety efforts by participating in safety committees and patient and family advisory committees,[7] as well as sharing their stories at meetings focused on safety, quality, and patient experience. Their involvement ensures that their perspective directs and informs decision-making and planning around the patient experience. In addition, high performers feature patients and their

[7] See, for example: *Guide to Patient and Family Engagement in Hospital Quality and Safety*. AHRQ; 2017. https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html

stories in communications (e.g., brochures, websites, social media) about their systems to highlight the system's focus on the patient and their experience.

A key distinguisher of high-performing systems regarding the link between safety and the patient experience is their intentional and reliable use of interactions with patients and their families to drive safe and quality care. These systems implement multidisciplinary and leader rounding, both of which include engagement with the patient and their family.

Multidisciplinary rounding (see sidebar for an example) is conducted at the bedside with multiple provider types, as appropriate for the respective unit. These rounds occur at the same time daily, as determined by the unit. The time for rounding is shared with patients and their families, and they are encouraged to attend and bring questions and concerns. During these rounds, the care team engages the patient directly, asking them questions and clearly explaining the care plan and next steps. The care team invites the patient and their family to participate in discussion and decision-making. The care team uses additional communication methods to complement rounding, such as leaving a daily care summary in the patient's room and enabling the family to receive text updates via the electronic health record (EHR). These coordination and communication actions support patient safety. For example, care team members can apply back-up behaviors to one another, such as a nurse reminding a physician to put in a patient order that was discussed during rounding. In addition, the high-performing systems found that when patients and families are able to access and communicate with the broad care team, as well as observe the team members' coordination with one another, it has a positive impact on the patient experience and, ultimately, on HCAHPS scores.

Houston Methodist Baytown designed and implemented multidisciplinary rounding as a way to improve the patient and family experience, reduce provider burden, and improve care coordination and quality. The effort required significant planning to ensure that each unit had multiple providers (e.g., physician, bedside nurse, charge nurse, physical therapy, social work, pharmacy, dietician) together at the same time each day. The quality team used data to overcome initial resistance from the bedside care team and to demonstrate that this approach would improve the patient experience. Patients and their families are informed of the time of rounding in advance, so they can bring their questions. The process, which uses a checklist to guide the structure, reduced multiple communications between nurses, families, and physicians by centralizing the sharing of information and coordinating on decisions. The improved patient experience scores were so significant that it has been replicated at other Houston Methodist hospitals.

High-performing systems also implement leader rounding. These rounds offer an additional opportunity to improve safety and the patient experience. High performers conduct leader rounds daily, including on the weekends, and they schedule time to conduct rounds during the night shift. Some leaders round on a separate schedule. For example, the chief executive officer for a hospital in one of the high-performing systems shared that she rounds once a week. During these rounds, leaders such as hospital administrative leads and department leads observe the care environment and look for issues that could impact safety, hear the concerns of the workforce, and engage directly with patients and their families to receive their feedback. Within one system-level board, its quality and safety committee members are expected to participate in leader rounding. By doing so, they have found that the workforce feels comfortable approaching them with ideas or concerns. Leaders use what they learn during rounding to prioritize action plans and help remove

barriers to addressing improvements. For example, one system moved patients' television audio to come through their call system at the bedside in an attempt to reduce noise in the unit. However, this approach was not loud enough, and during leader rounding, they noticed that patients were leaning on the bedrails to hear their television. They promptly created an action plan to address this safety issue. One system conducts a specific form of leader rounding that they call "patient safety rounding." It involves hospital quality leaders, infection prevention leaders, and even supply chain managers. During rounding, they observed and spoke with the workforce about hallway beds in the emergency department (ED). Being able to see how these were used helped them identify safety issues that they could address, such as adding call lights and curtains, and securing sharps containers.

Change Concept: Prioritize the Psychological Safety of the Workforce to Encourage Safe Care

Safety Culture

High performers prioritize the psychological safety of the workforce to ensure they feel safe to speak up and voice safety concerns. They focus on processes, and balance system and personal accountability when a safety event occurs. They recognize that workforce psychological safety allows a system to create and sustain a speak-up culture. When the workforce feels safe, they are empowered to deliver safe patient care.

High-performing systems recognize that safe patient care is not possible without a workforce that feels safe. High performers address this in multiple ways. For example, as an aspect of promoting a culture of safety, these systems communicate the importance of and encourage transparency in safety reporting. Messaging about reporting—as well as the event review process itself, which is rooted in just culture principles—emphasizes that the focus is on the process or breakdown that occurred (i.e., what occurred and why), rather than the person or people involved. High performers also permit anonymous reporting to maximize the likelihood that events are reported and addressed. One system regularly reviewed safety reports and good catches to identify those that had a notable positive impact on safety, and they acknowledged individuals who reported the events or good catches with a "Safety in Action" certificate.

As part of high performers' alignment with just culture principles, they have an intentional focus on encouraging and reinforcing speaking up behaviors. They train the workforce to speak up by providing tools such as CUS (I'm **c**oncerned, I'm **u**ncomfortable, and this is a **s**afety issue) and Stop the Line. They use safety meetings and daily huddles to remind the workforce to speak. For example, during one system's morning unit-level huddle, the nurse manager encouraged the workforce to review patients' orders and to ensure that they were appropriate. She encouraged the workforce to question the orders and to use CUS to raise concerns. High performers also recognize the role of leaders in fostering a speak-up culture. One system emphasized the importance of leaders being approachable to the workforce as a key contributor to a culture where the workforce can speak up and feel psychologically safe. They include this as part of their leadership development training.

When the workforce needs support, high performers have resources to address well-being. For example, systems provide activities that align with the American Medical Association's Joy in Medicine® initiative, which focuses on reducing physician burnout, and implement caregiver support programs such as the Johns Hopkins Resilience in Stressful Events (RISE) program. In addition, high performers leverage both access to trained professionals (such as through an employee assistance program) and peer resources to support the workforce during times of stress or hardship. One system complements workforce well-being retreats with a formal peer support program. The program uses peer volunteers who know the healthcare system and have likely had similar experiences to those their peers may be navigating to help promote healing and improve psychological safety.

Strategy: Safety Culture is Strengthened by Regular Review of Safety Data to Generate Knowledge and Drive Improvement

Change Concept: Support Robust Safety Event Reporting and Review

Safety Culture

High performers expect the workforce to report safety events/concerns and use structured methods to analyze events and drive improvement.

High-performing systems demonstrate a commitment to event reporting by immediately setting the expectation for the workforce to report events, such as in new employee orientation. This includes teaching the workforce how to report and what an effective safety report looks like. High-performing systems also ensure that reporting is accessible by enabling the workforce to access the reporting system in multiple ways, such as on the internal system website and through the EHR. The system itself—often as a result of iterative user testing—is designed to make it easy for the workforce to report the information that is necessary for an effective report that will drive action. Effective reporting systems also facilitate easy data collection and review, such as being able to easily retrieve data, generate reports, and analyze trends. High performers do not limit reporting to the healthcare workforce. They enable patients and families to report safety events through mechanisms such as a hotline, and they use passive reporting processes (e.g., event logs generated from EHR documentation, diagnostic testing, and claims-based data) to trigger the event reporting process.

High performers not only set the expectation for reporting but also provide positive acknowledgement of individuals for reporting, as a way to reinforce the behavior. For example, one system regularly reviews safety reports and good catches. Individuals who report events or good catches that are identified as having a significant impact on safety are acknowledged with a "Safety in Action" certificate. Another system reviews and selects good catches to present to its board. Not only do high performers acknowledge the workforce for reporting, but they close the loop with those who report. For example, local managers are expected to communicate actions resulting from the report back to the individual who reported the event. One system sends approximately 1,000 thank you cards each month to every person who submitted a report. The cards are designed in-house monthly and have become collectibles among the system's workforce. They serve to acknowledge receipt of the report and reinforce the importance of reporting.

High-performing systems recognize that safety event reporting and good catches are only impactful if they are analyzed and result in clear action plans. They establish reliable and timely processes to review reports and good catches, including flexible levels of review, depending on the nature of the report. For example, systems develop scoring methods (e.g., a patient safety risk assessment matrix) to ensure that the appropriate type of review is conducted, and they use a multidisciplinary team that is pulled together based on the nature of the event to conduct the review. Levels of structured review and analysis may include a root cause analysis (RCA), RCA "light" (see sidebar for an example), or failure mode and effects analysis. One system also conducts unit-level, real-time huddles with the workforce upon identifying a near miss so that challenges and solutions can be discussed immediately. High performers teach their workforce how to participate in event reviews, such as by participating in and/or observing mock review sessions. The review process includes input from the workforce involved in the event, with an intentional focus placed on the process and procedures that can be improved, rather than the people involved. One system invites a few residents to participate in every RCA as a way to embed the importance of reporting and analysis as a driver of safety into the mindset of new physicians. Action plans resulting from each event review include clear steps, assigned responsibilities for actions, and a timeline. They are tracked in a transparent manner, such as in a spreadsheet or on the daily huddle board, to enable the workforce to follow the progress of the action taken.

As part of the **St. Luke's University Health Network's** commitment to transparency and operating within a culture of learning, they use multiple levels of event reviews, triggered by the nature of the event. For example, for non-sentinel events, they conduct an intense analysis, or what they refer to as a "root cause analysis light." In general, these are conducted within 14 days of the event and led by the patient safety officer. Individuals involved in the event gather together in person to discuss what occurred; breakdowns and contributing factors; and the appropriate action plan. An important focus of the intense analysis is on supporting workforce well-being after an event. In addition, the patient safety officer leads workshops to train the workforce to participate as effective members of the intense analysis process.

The final step in maintaining a robust safety event reporting and review process relates to communication about the event. As discussed previously, a closed loop with the individuals who report an event is necessary. High performers communicate safety events and good catches broadly and through multiple channels, such as board meetings, safety huddles, system- and hospital-level safety meetings, and systemwide communications with the workforce. High performers also leverage system-level unit directors' meetings and service line-level meetings to ensure that events and solutions are discussed and shared broadly.

Change Concept: Leverage Data to Drive Decision-Making for Safety

Safety Culture

High performers use objective data to make safety decisions. They monitor data in close-to-real-time and present it in ways that can be operationalized through quality improvement activities.

High-performing systems describe themselves as "data obsessed." They use objective data to guide decision making and they recognize the need to access and use data in order to identify gaps and monitor improvement. This includes ensuring that data and reports are accessible, timely,

accurate, and presented in a way that facilitate action. In addition, high performers recognize that too much data or data that are no longer relevant can be a distraction to those who need it. To mitigate this, they put processes in place to ensure that data tools and resources are reviewed at least periodically to assess their relevance and usefulness (e.g., using access metrics) and prioritize additional data needs.

A common strategy across high performers for using and monitoring data is the use of dashboards or other data visualization tools to track baseline data and progress over time. For example, one system uses dashboards that can be accessed during board meetings or other leadership meetings to drive decisions about priorities. The dashboards are also made available to the workforce without the need to make a request through the quality and safety team. One system presents data on their daily huddle board in each unit to promote transparency about unit-specific, data-driven improvement efforts and progress toward established goals. In some instances, specific unit-based dashboards are also implemented. For example, one ED uses a dashboard to track a patient's progression through the unit in real time (e.g., arrival time to lab order; arrival to imaging order; arrival to first provider) and monitors the timing against unit-based goals.

High-performing systems also monitor benchmarks to drive improvement. For example, using data internal to their system, high performers make data available to support benchmarking at multiple levels, such as balanced scorecards at the system and hospital level that are transparent systemwide. They provide hospital-level dashboards or reports that all hospitals in the system can view, as well as unit- or provider-level data that can be shared transparently to share successes and opportunities for improvement. The high-performing systems noted that allowing hospitals, units, and the care team to benchmark themselves against others often supported "healthy competition" that drives improvement. External to the system, high performers make effective use of publicly available data, such as safety outcomes data and patient experience data from CMS. They also partner with organizations that support healthcare quality improvement (e.g., state hospital associations, membership organizations) from which the system obtains access to data they find useful for benchmarking at national or regional levels, as well as exploring comparisons to systems with similar demographics.

A specific characteristic of high-performing systems is their use of real-time data to support clinical decision making. For example, these systems effectively use their EHRs to ensure that providers have data and information at their fingertips and can take timely action when data are out of range. More notable, however, is their use of additional technology to support real-time and retrospective decision-making. For example, one system implemented continuous pulse oximetry monitoring that serves as a "safety net" to drive patient outcomes. For hospitals with the resources to do so, a nurse monitors the data from patients in real time on the floor. In smaller hospitals, they use the system's virtual response center to support monitoring by a remote workforce. This real-time data is used to identify patient decompensation early. It has resulted in outcomes such as preventing failure to rescue events, reducing sepsis mortality, and decreasing alarm fatigue. Another system implemented an artificial intelligence (AI)-based technology in their operating rooms systemwide. The technology uses cameras in each operating room to generate data about intraoperative milestones (e.g., patient arrival preparation, surgery, room turnover). The data are monitored by the charge nurse both in real time to support decision-making related to

opportunities, such as improving turnover times and increasing adherence to environmental services protocols.

High-performing systems also leverage all available data to support quality improvement efforts. This includes clinical outcomes, as well as culture of safety survey data (e.g., AHRQ Surveys on Patient Safety Culture®, or SOPS®, Hospital Survey) and patient experience data (e.g., CMS HCAHPS survey), among other system-level data sources. They proactively review the latest data to develop and implement action plans, and they review data over time to identify trends that may support prioritization of actions. In addition, high performers monitor quality improvement data at the system and local levels. For example, one system maintains a database of all quality improvement projects, including any available outcomes data, to provide a searchable historical record across the system. At the local level, examples of additional ways in which high performers use data to support quality improvement include presenting unit-level data as part of daily huddles or through technology like web-based dashboards with real-time communication, feedback, and updates to identify opportunities for improvement and monitor the effectiveness of interventions. In addition, one system's unit-based shared governance councils review safety reports monthly to identify trends that could inform unit safety projects for the council to address.

Strategy: Disseminate and Diffuse Best Practices and Innovation Across the Healthcare System

Change Concept: Provide Robust Training Opportunities that Establish and Maintain Safety Competencies

Safety Culture

High performers offer multiple opportunities for competency-based training that is grounded in their values, including safety, quality, and patient experience. These competencies are consistently reinforced with the workforce, beginning with orientation.

One way in which high-performing systems demonstrate their commitment to safety is through their inclusion and reinforcement of workforce training and development. New employee orientation includes a focus on safety competencies and tools, such as through dedicated segments of training taught by a hospital- or system-level safety and quality lead. In addition, the workforce participates in mandatory annual training during which safety competencies are reinforced. Leaders also participate in robust training that develops their knowledge and skills in safety, quality improvement, and patient experience. In addition, high-performing systems address emergent training needs, such as unit-based training on new processes or procedures that are implemented as a result of a safety event or performance improvement project.

High-performing systems leverage various training approaches to develop their workforce's safety skills. The three high-performing systems use approaches such as providing the workforce with scripting or tools to support their reliable use of processes. For example, one system uses a card that fits behind employee badges (a "badge buddy") to remind them of the information to report about each patient during multidisciplinary rounds. High performers also make effective use of scenario-based training. Scenario-based training can be conducted as role play or through more formal simulation-based training, including the use of standardized patients—or actors who

portray patients to provide realistic training scenarios. The high-performing systems and their hospitals may have variable access to high-fidelity training resources. For example, one system has a simulation lab available in its flagship location for the entire system's use. Another system deploys a simulation van with equipment to conduct simulation training to the system's rural hospitals for onsite training opportunities.

Change Concept: Support Multidirectional Transparent Communication

Safety Culture

High performers create channels for open and transparent communication across all levels of the healthcare system, ensuring workforce and patient voices are heard and addressed. They use multiple modalities for real-time communication, both informal and formal, and consistently close the loop with timely feedback.

High-performing systems use multiple modalities to facilitate multidirectional communication with the workforce, patients, and their families. This includes leaders and the workforce sharing plans with and obtaining ideas from one another.

High performers conduct multidirectional and transparent communication with the workforce through various means. They use structured daily, weekly, and monthly meetings that engage multiple levels of leaders as an opportunity for (1) system-level leaders to share information with hospital- and unit-level leaders, and (2) hospital- and unit-level leaders to share information and concerns with senior system-level leaders. At the local level, high performers implement and use multiple modalities of communication, recognizing that there is not a one-size-fits-all approach to how the workforce receives information, particularly during busy times and times of stress. For example, high performers leverage virtual platforms to communicate information related to safety across units, departments, and leadership teams. One system demonstrated the effective use of a collaboration platform, which the workforce can access on their mobile phones, to share safety-relevant updates in real-time and to elicit topics and questions for the team's discussion.

Another common form of communication among high performers is the use of unit-level daily management boards that leaders use to share data and updates related to safety activities and priorities. They encourage workforce input during daily huddles, where the information is reviewed and discussed. The workforce can also provide input outside of the huddle format, such as by submitting ideas or recommendations. For example, one system uses "voice of staff" paper tickets that are posted on the daily huddle board for transparent discussion and tracking toward resolution. Another system shared an effective use of an "e-idea box" from which ideas are populated into a spreadsheet to track progress and ensure the nurse manager closes the loop with the workforce.

As part of their work to put the patient experience at the foundation of patient safety, high performers establish open communication channels with patients and families. They inform patients and families about these channels upon hospital admission, and they invite and encourage their engagement throughout the care process, including during multidisciplinary and leader rounding. Outside of the care process, high performers also engage patients and family members in safety councils and advisory committees. One system also hosts community meetings twice a year that are designed specifically to obtain feedback from patients and prospective

patients. One high performer locates its patient experience office in each hospital's lobby to further promote multidirectional and transparent communication with patients and families by making it more accessible for patients to receive information, ask questions, and share feedback.

Change Concept: Implement Changes with Intention Based on Contextual Knowledge

Safety Culture

High performers leverage change management and implementation science principles to maintain an appropriate balance between standardization and planned adaptation to local needs. They approach the rollout of safety plans with clear intention, while actively seeking feedback from all interested parties and monitoring the results of changes.

High-performing systems demonstrate effective change management and application of implementation science principles to improve safety. In particular, high performers understand and appropriately address the need to consider local context in implementing change. This includes effectively implementing standardized key processes across the system, while using phased implementation and/or planned adaptation where appropriate. For example, when one system implemented the continuous pulse oximetry monitoring discussed previously, the same policies and standards were required across the network for its use. However, hospital-specific monitoring procedures (e.g., in-person versus remote, virtual monitoring) and the equipment used were determined based on the specific hospital's resources. Similarly, when another system implemented multidisciplinary rounds, hospital units were given flexibility to determine the time of day that the rounds would occur, based on the workforce's needs and preferences.

High performers also demonstrate their understanding of the criticality of communication in strong change management. They tailor messaging to various stakeholders to clearly communicate the plans, goals, and "what's in it for me?" They also make an intentional effort to learn from late adopters or resisters, so that barriers to implementation can be addressed. As an example of the role of communication in change management, one system proactively generated buy-in for the implementation of multidisciplinary rounds. They did so by communicating existing evidence about the impact that multidisciplinary rounds would have on patient safety. Another system shared an example of their method for implementing a new protocol where leaders communicated the plans, spent time using the protocols with the nursing staff, and had open, collaborative conversations about how to help others become comfortable with the change.

Regarding their effective application of implementation science, high-performing systems identify a singular quality improvement method (e.g., Plan Do Study Act [PDSA] or Define, Measure, Analyze, Improve, and Control [DMAIC]), train their workforce in its use, and use it reliably across improvement efforts. They effectively design and implement small tests of change; transparently share processes and results; and assess the results to make decisions about and plan for broader dissemination. For example, one system used its patient safety data to identify a need to reduce catheter-associated urinary tract infections (CAUTI) rates in one hospital. They initiated a quality improvement project, beginning with identifying a hospital executive to lead the effort. The team created a specific action plan with goals and established a task force for the effort to report progress monthly. The team implemented small tests of change to redesign and audit the process of placing urinary catheters in one unit, which improved its rates to zero CAUTIs. The results were

presented in safety meetings that enabled sharing with other units and hospitals. In addition, the system planned for and implemented the improved processes and procedures in other units and hospitals.

Another aspect of high performers' application of implementation science is how they engage and support physicians in quality improvement. High performers create structures that enable physician champions in safety and quality to be supported by safety and quality professionals. For example, one system employs performance improvement advisors to apply DMAIC as the system's quality improvement methodology and manage improvement projects. The advisors work closely with the workforce to ensure that they are involved in designing solutions to issues and determining how to implement the solutions.

Primary Driver: Leaders Embody, Cultivate, and Reinforce the Safety Culture

This primary driver focuses on leadership and the role of leaders in establishing and maintaining a strong safety culture. Based on practices gleaned from the high-performing systems, this driver is influenced by three strategies:

1. **Leaders set expectations of excellence in safety.**
2. **Leaders purposefully develop other safety leaders.**
3. **Leaders care for their people.**

Strategy: Leaders Set Expectations of Excellence in Safety

Change Concept: Leaders Model Behaviors and Hold Themselves Accountable to the Healthcare System's Values

Leadership

High performers expect leaders to model safety behaviors and create pathways to ensure leaders are approachable and accountable for a culture of safety.

Healthcare systems cannot be high performers without leaders who individually demonstrate and hold themselves accountable to safety behaviors modeled on the values of the system. By doing so, they also serve as key role models in cultivating and preserving the system's safety culture.

High-performing systems have leaders who take accountability for upholding the values of the system as an integral part of achieving top safety performance. For example, their job descriptions and performance evaluation criteria specify expectations related to their involvement in safety and quality, and their compensation is tied to performance on safety outcomes. This includes responsibilities related to identifying and remediating issues to improve safety, leading or participating in efforts to collect data, and conducting formal projects aimed at performance improvement, monitoring safety outcomes data, and participating in safety committees. Leaders in high-performing systems are responsible for setting and communicating expectations about safety to patients and the workforce. This includes communicating safety goals, progress, and outcomes. Leadership accountability is upheld by the governing body as described later. It also includes

leaders leading by example (see sidebar for an example) and maintaining visible roles and intentional engagement in activities such as safety meetings, leader rounding, and tiered huddles.

Importantly, high-performing systems also set expectations for leaders to be available and approachable. This is coupled with a focus on ensuring leaders model—and are trained in—characteristics such as humility, emotional intelligence, and critical self-analysis. In fact, high performers offer coaching to leaders who demonstrate gaps in these types of characteristics, and if they cannot close those gaps, the leader will be coached out of the system. One system includes expectations about these leader characteristics in some job descriptions and refers to it internally as the "no jerks clause."

When the **Mayo Clinic** implemented daily tiered huddles, they were concerned about potential pushback about the time required to participate. Leadership, however, set participation as the expectation; the activity is not viewed as an addition to their job, but it *is* the job. Leaders lead by example during the huddles, actively listening to patient safety updates and concerns and proactively asking, "What can I do to help?" The process has also created more efficiency (e.g., fewer additional meetings and emails) by getting the right people together to address a need or issue.

In addition, high performers provide consistent messaging to the workforce that it is acceptable to try something new without consequence if it fails. They reinforce that what is important is learning from what they tried and sharing the learning with others who can build on the lessons learned.

Change Concept: Leaders Recruit and Retain a Workforce Representative of the Healthcare System's Values

Leadership

High performers prioritize recruiting a workforce based on cultural fit. Job descriptions emphasize safety, and the workforce is held accountable for providing safe, high-quality care.

High-performing systems invest in their workforce as a key driver of safety and safety culture. They have established recruitment and vetting processes grounded in the system's values to ensure alignment with their culture and values. For example, one system has a structured vetting process for new employee selection that includes multiple rounds of interviews with multidisciplinary teams, including personnel at various levels of the system. High performers train leaders and other personnel in identifying success factors during the selection process. The extensive process is viewed as an important upfront investment in the workforce. They acknowledge that "nobody does their job alone," and that aligning the workforce around shared values is an important component of providing safe care.

These same priorities are evident as high-performing systems focus on retaining a workforce that is aligned with the culture and values of the system. For example, high performers view investments made to develop the workforce and promote from within as necessary for keeping the workforce engaged and committed, and for preserving the culture and institutional knowledge of the system. The focus on career advancement includes offering multiple opportunities for individual growth, starting with a culture of support for new members of the workforce and for those who move into new roles. In addition, high performers offer training, mentoring, and coaching to develop the workforce. Leaders consider where individuals can best apply their skills and interests in the

system and work with individuals to help them gain knowledge and skills. This includes leaders sharing lessons learned from their own experiences. High performers also make opportunities transparent to the workforce. For example, one system has clear descriptions of workforce responsibilities, advancement opportunities, and resources posted throughout its hospitals, including "clinical ladders" for nurses and other clinical workforce members. The system ensures workforce strengths and interests are well understood to recognize potential future leaders within the system.

High-performing systems also prioritize preserving their culture and values through leadership. This is done through internal promotion and by setting clear expectations of leadership behavior. These systems are proud of their culture and recognize the need to sometimes provide coaching and support to leaders who are not demonstrating behavior consistent with the system's culture and values. The systems see the investment in preserving the culture as critical, and they have processes to manage out those who do not demonstrate the values of the organization.

Strategy: Leaders Purposefully Develop Other Safety Leaders

Change Concept: Leaders Regularly Engage with the Workforce About Safety

Leadership

High performers actively support leaders to model the culture of safety through rounding and regular engagement with the workforce and patients.

High-performing systems support and expect leaders to engage the workforce and patients as a driver of safety. This leadership behavior is considered critical to the culture of the organization. Leaders' visibility and engagement enable them to build relationships and trust with the workforce, and they support their efforts to be accountable for safety. High performers use leader rounding as a structured opportunity for leaders to engage with the workforce, observe processes with a focus on safety, and invite the workforce to share feedback, concerns, and questions. Leaders play an important role in documenting what they learn, assigning action items, and ensuring closed-loop communication so that the workforce is aware of how their feedback was addressed. Similarly, during leader rounding, leaders engage with patients and their families, including asking them about their experience and listening to their questions and feedback.

Among high performers, quality improvement activities also facilitate leader engagement with the workforce and accountability for safety. For example, one system conducts periodic observations and interactions with the frontline workforce (i.e., Lean Six Sigma Gemba walks) to gather information for improving safety. Another system discussed the use of their safety culture and staff engagement surveys as opportunities for the workforce to provide feedback to system-level leaders. The system described how they respond to opportunities for improvement that these surveys highlight by hosting listening sessions with the workforce to learn more. Leaders focus on hearing about the "pebbles in their shoes" and identifying themes on which they can take action.

Part of the intentional visibility of leaders is accomplished through structured reporting systems, such as team huddles, to ensure clear communication at all levels of the organization. For example, one high-performing system implemented a tiered safety huddle process that engages the workforce to communicate frontline activity to leadership through a series of structured

communication processes that can rapidly escalate concerns, accomplishments, and progress to all levels of system leadership. Leaders are expected to actively participate and listen to reports from multiple levels of the system. They proactively ask how they can help, and they seek to remove barriers, participate in solutioning, and support resource allocation.

In addition, leaders in high-performing systems play an important role in establishing a process for safety event review, analysis, and response. Importantly, they ensure that the review focuses on identifying processes for improvement rather than individual accountability. Leader involvement in event reviews ensures timely review, analysis, and response because of the leader's accountability for safety that systems establish in alignment with their values, as described previously. By focusing on process improvement over personal accountability, leaders and the workforce collaborate on solutions and action planning, while the leader takes accountability to monitor progress toward resolution and share information with others affected by the event review and subsequent actions.

Change Concept: Planning as a Tool to Cultivate Leaders and Sustain Organizational Culture

Leadership

High performers intentionally assess leaders for cultural fit and develop leaders through mentorship and succession planning.

High-performing systems establish succession planning as a key responsibility for leaders. This is accomplished through formal processes such as career planning and leadership training, and informal processes such as mentorship (see sidebar for an example). For example, one system has an extensive succession planning process that involves formal leadership assessment, leadership training, mentorship, and structured transitions. The transitions often involve the senior leader identifying a deputy or associate to shadow and receive coaching from the senior leader over a one-to-two-year period. Then, as part of the transition process, the emerging leader steps into the new role while the outgoing leader serves as deputy to continue to provide coaching and advice. This intentional approach to succession planning is viewed by high performers as critical to preserving system knowledge, values, and culture. One leader said that succession planning is "one of [their leaders'] most important roles."

St. Luke's University Health Network cites its culture as one of its strongest assets, crediting its leaders for cultivating and preserving the culture. The foundation of this culture is a robust process for selecting and developing leaders and conducting formal succession planning to prepare for transitions. The workforce is trained in how to assess success factors during the interview process and through working with current leaders to identify talent. New and emerging leaders are offered support and provided with mentoring. Among physicians, leaders actively cultivate the next generation of physician leaders for succession planning. This includes formal leadership training and workshops, as well as long-term mentoring. One example given of this is when a department chair appointed three associate chairs with whom he met monthly to go through a leadership book, discuss experiences, and share practical advice and coaching. He assigned the associates tasks in quality, such as reviewing and presenting quality and safety data. This type of long-term mentorship helps ensure that the organization matches the right people to positions, as they recognize that the organization cannot move to a higher level of performance without the right people.

High-performing systems intentionally grow and promote leaders from within, prioritizing cultural fit and commitment to the system's values over clinical recognition or prestige. As one system described, it is critical to "rally around" new leaders and support them from the start. Leaders are also trained to recognize talent from within the organization and develop it. Leaders in high-performing systems mentor several individuals to create a pool of potential future leaders to coach. They may use "stretch assignments" as a way to identify potential leaders who may be appropriate for further development and inclusion in more formal succession planning.

Strategy: Leaders Care for Their People

Change Concept: Intentionally Lead Efforts to Support Workforce Well-being and Psychological Safety

Leadership

High performers recognize that well-being and psychological safety are fundamental to safe patient care. They also consider workforce well-being and safety key drivers to reduce burnout and turnover.

High-performing systems have leaders who support a culture of safety and workforce well-being. The concepts of psychological safety are inherent in the culture, as noted through the examples of psychological safety and well-being discussed previously. Leaders help communicate the availability of resources like peer support and employee assistance programs. They also ensure that members of the workforce are trained to facilitate sensitive discussions, such as helping others cope after a safety event or other stressful situation. In addition, leaders support psychological safety by encouraging the workforce to speak up and ensuring that the workforce feels supported and heard when they speak up.

Leaders in high-performing systems are sensitive to signs and drivers of workforce burnout and actively pursue opportunities to understand and alleviate causes of burnout. For example, one system leader shared a story in which a physician told them that the work they had to take home with them was affecting time with their family. The leader took action and maintained accountability to find solutions to improve and minimize the time spent charting. Although there was no immediate solution, when the leader approached that same physician, asking them to try a new charting process, the physician expressed immense gratitude that their concern was heard and being addressed. In another system, a leader simply said, "my job is to listen to people and make sure they trust that I'll take action." Additionally, when workforce performance or safety issues are identified, leaders in high-performing systems recognize that individual circumstances may underlie performance, and they ask about well-being before asking about performance or technical skills. By supporting well-being, high performers show an ongoing commitment to their workforce and increase the likelihood of workforce retention.

Change Concept: Empower the Workforce to Initiate Changes

Leadership

High performers empower the workforce to identify opportunities and solutions for improvement across the healthcare system.

High-performing systems have a workforce that is empowered to identify and address safety concerns as part of their work. These systems have structures in place to address systemwide process improvement opportunities. At the same time, system-level leaders establish the expectation that the workforce can identify solutions and test them without system-level oversight. High performers often empower their middle managers, such as service line or unit managers, to support decision-making around and efforts to address safety improvements (see sidebar for an example). Higher-level leaders are engaged to remove barriers or provide resources when necessary. The balance between systemwide approaches to addressing safety concerns and frontline autonomy to ensure safe care is ingrained in the culture of the organization; they recognize that "everyone is a subject matter expert," and safety is "everyone's responsibility." In addition, high performers recognize that engaging the workforce in developing solutions helps to keep them motivated and facilitates buy-in when changes are implemented.

In the **Mayo Clinic Rochester's** surgical intensive care unit, nurse managers implemented an "e-idea box," to which the workforce can submit ideas or raise issues. The workforce was encouraged not to use the tool as a modality for venting but rather to share issues they experienced in their work and proposed solutions. The ideas are populated into a spreadsheet-based tool to monitor continuous improvement (e.g., Kaizen board) that helps the nurse managers track the progress and close the loop with individuals who submitted ideas. Leaders use daily, unit-based huddles to discuss changes to processes and put particular emphasis on the fact that changes are a result of ideas from the workforce.

High-performing systems also have mechanisms in place for leaders to monitor whether the workforce feels empowered to address safety concerns. For example, high performers use workforce assessments, such as employee engagement surveys, to assess whether the workforce feels heard when concerns are raised and to monitor perceptions of leader accountability.

Change Concept: Recognize and Appreciate Workforce Achievements: "Celebrate the Wins"

Leadership

High performers have well-developed programs tied to their values that recognize workforce achievements and engagement in intentional and endurable ways.

High-performing systems have multiple practices and programs through which leaders encourage and reinforce the workforce's ownership of safety. When leaders recognize groups or individuals in ways that are meaningful to those doing the work, the workforce feels appreciated and heard. For example, leaders at high-performing systems celebrate workforce achievements through practices such as an email or message recognizing individuals or groups for their work on safety, including good catches. Other examples include group celebrations and escalating acknowledgement of an achievement through the system, such as through tiered huddles or in board meetings.

Leaders in high-performing systems also establish more formal recognition programs and awards. These programs and awards may be systemwide recognitions or specific to subsets of the workforce, such as annual physician or nursing awards for safety and quality. One system has an annual quality award to which anyone within the system can apply. It is upheld by leaders as an acknowledgement of excellence in safety and has become a systemwide celebration and

recognition. Leaders promote and encourage participation in the quality awards, so that the workforce sees value in submitting work for consideration and appreciates the opportunity to be visible to leaders. The entire system recognizes the award as a premier achievement in quality and safety, and the achievements of awardees are broadly communicated. Another system established a "gold badge" program that recognizes individual achievements that demonstrate the system's values. Through a formal process, individuals are nominated by their peers for their achievements. Awardees are recognized with a gold employee badge that they wear proudly and that is visible to peers and patients. These and similar programs provide examples of how systems create enduring recognition of excellence within the workforce.

Primary Driver: Governance Structures and Strategic Planning Support Safety

This primary driver focuses on governance structures and the role of the governing body in establishing and supporting safety. This driver is influenced by one strategy:

1. **Govern with intent**.

Strategy: Govern with Intent

Change Concept: Proactively and Purposefully Embed a Shared Values-based Vision and Strategy for Safety

Governance

High performers recognize safety as a core value critical to their patient-focused mission. The vision is clearly communicated and embodied across all levels, guiding short-term decisions and long-term strategic planning—leading to a strong, visible culture of safety.

Each of the three high-performing healthcare systems demonstrates safety as a core value that drives their mission and vision. In addition, each system demonstrates a strong values-based approach to safety. They have memorable acronyms to communicate their values to the workforce, patients, and the community, and they also communicate the values as "non-negotiables." The values are displayed in the work environment, and all levels of the workforce know the values and how to apply them in their work and behavior. Houston Methodist's values are communicated through I CARE, which stands for **i**ntegrity, **c**ompassion, **a**ccountability, **r**espect, and **e**xcellence. The Mayo Clinic uses RICH TIES to communicate its values of **r**espect, **i**ntegrity, **c**ompassion, **h**ealing, **t**eamwork, **i**nnovation, **e**xcellence, and **s**tewardship. St. Luke's University Health Network established PCRAFT, which stands for their values of **p**ride, **c**aring, **r**espect, **a**ccountability, **f**lexibility, and **t**eamwork.

Each system develops and communicates strategic plans that focus on its values, mission, and vision. This includes short- and longer-term strategic planning. An example that includes both short- and longer-term strategic planning is around the thoughtful investment in and use of AI to support the vision of achieving top performance in national quality measures, patient satisfaction, and access measures. After establishing a governance structure specific to the use of AI in the system, one system started with a short-term plan to identify (1) what patient safety improvements could be addressed with AI and (2) what AI solutions the system could explore and test—either

through investment or partnership with technology solutions firms. Their longer-term strategy involves assessing the use of AI-based solutions to achieve specific patient-centered goals, such as reduced time to receive imaging results. The longer-term strategy is also closely tied to succession planning to ensure that the work engages developing leaders who can continue to advance these plans, if and when leadership transitions occur.

High-performing systems use their values to guide decision-making and prioritize resources, as well as align improvement projects and other initiatives with values. Based on observations of the high-performing systems, decisions are consistently considered with regard to their impact on patient safety and experience, aligning with their values, mission, and the strategic vision for the system. A common theme is the mindset of doing the right thing for patients first and then looking for ways to secure needed financial support, including through means such as grants and partnerships with other organizations. Similarly, these systems focus their improvement efforts on their values. For example, in alignment with one system's values around respect and flexibility, the workforce is encouraged to identify improvement needs that drive patient safety and experience and to design and implement small tests of change to address the needed improvements. Using a PDSA cycle, those who lead change efforts assess the effectiveness of the tested intervention or change and share the results broadly to promote learning and scale-up, where appropriate. Sharing the results aligns with the system's consistent messaging from leaders that the workforce can try and fail without consequence, as long as they learn from what they tried.

Finally, high-performing systems use a variety of activities to recognize their values and reinforce their consistent application by all members of the workforce. For example, the annual quality awards program described previously has specific award criteria that align with the system's values and mission, thereby creating another avenue for communicating and reinforcing commitment to these and recognizing the role of the workforce in maintaining a culture strongly rooted in the values. The "gold badge" program described previously was purposefully designed around the system's values and serves as a visible reminder of the system's values to the workforce and patients.

Change Concept: Create and Maintain a Structure for Collaboration and Accountability to Support Safety Across the Healthcare System

Governance

High performers maintain a governance structure underpinning their safety program that supports values-based decision-making, collaboration, and accountability across the system. The governance structure facilitates the patient and workforce experience from the unit level, across disciplines and specialties, up to the governing board. The governance structure also provides a mechanism to disseminate and standardize safety practices across the healthcare system, while allowing for adaptation as needed to respond to varying local conditions. Clinical and administrative leaders are held accountable for collaborating on safety decision-making.

High-performing systems leverage multiple levels of governance, such as a systemwide board, system-level leaders in safety, and hospital-level leaders in safety. The system-level governance provides a centralized resource to all system entities in providing direction and support on safety, quality, patient experience, and data analytics. Those within the centralized structure work closely

with leaders and the workforce at the hospital and unit levels for cross-directional communication and learning that ensure systemwide alignment while reflecting the needs, concerns, and context of the workforce. A common practice among high performers is to establish leadership structures that pair administrative and clinical leaders – either through a dyad consisting of an administrative leader and a physician leader or through a triad consisting of an administrative leader, a physician leader, and a nurse leader – to ensure that multiple perspectives are considered in decision making around safety.

High-performing systems also demonstrated that their governance structure was foundational to their safety program by supporting values-based decision-making, collaboration, and accountability. This was observed in multiple ways across all three systems. First, the high-performing systems prioritize identifying and recruiting effective, inspirational, and values-driven safety champions to their governing body (see sidebar for an example). One system made an intentional decision to recruit local versus national board members to ensure that the governing body was not only passionate about safety, but passionate about the safety of the patients and healthcare workforce in their community. Similarly, another system makes effective use of members of the community to drive improved patient safety and experience by inviting them to serve on committees (e.g., patient and family advisory committees, quality and safety committees) and engaging them in meetings where they can share their feedback. Each system's governance structure also supports its values by putting safety at the forefront of governance activities. For example, board meetings start with a report from the quality and safety committee, and leadership meetings are framed with the voice of the patient. In addition, the governing body leads and participates in discussions centered around safety data, including opportunities for improvement, successes, and notable good catches. The members of the governing body know the safety performance and outcomes data for their system and can engage in meaningful discussion about it, and they actively seek to remove barriers to drive improvement. In addition, the members of the governing body play an active role in understanding the context around the data, such as by spending time on site at each hospital in their system, observing processes and practices, and engaging with the workforce to hear their concerns and ideas for solutions.

The **Houston Methodist** system's Board of Directors includes an active Quality and Patient Safety Committee. The committee's chair, who is also the Vice-Chair of the Board of Directors, describes herself as passionate about quality and safety, and noted that this engaged group feels they have the "ultimate responsibility for quality and patient safety," regardless of which hospital door a patient comes through. The committee members are expected to share the system's values and vision. In addition, they are expected to regularly visit each hospital to participate in safety meetings, huddles, and other activities, giving them an opportunity to observe processes and procedures that are common across hospitals while also appreciating how each hospital is different. To emphasize the importance of quality and safety, the board aims to have each of its members rotate through the Quality and Patient Safety Committee, and they begin each board meeting with the Committee's report.

Another way in which high-performing systems establish and maintain accountability is by implementing shared governance models. Shared governance empowers the workforce to be active participants in decision-making and action related to safety and quality. The high-performing

systems implement shared governance at the unit or department level. They use data and workforce feedback to identify potential improvement projects; design, implement, and measure the effectiveness of interventions to drive improvement; and share their work and results with other units or departments to promote cross-pollination of ideas. Regarding improvement projects, one high-performing system uses a systematic approach to ensure the most appropriate individuals are engaged in the project. Through a stakeholder analysis, they identify who is needed to support effective problem solving, help remove barriers, and contribute relevant skills and expertise (e.g., clinical staff, technology solutions, administrative staff).

The governing structures of high-performing systems also establish and implement processes and mechanisms to ensure accountability for their values-based strategy and its role in achieving top safety performance. As discussed previously, this includes, for example, ensuring that leaders' job descriptions, performance criteria, and compensation set clear expectations related to safety and quality. The governing body also supports resource allocation for ensuring that the workforce is trained in safety competencies. By doing so across the system, it reinforces the expectation that everyone has a role in providing safe patient care.

High-performing systems demonstrate that a key component of governance in support of safety is establishing a timely, reliable, and responsive approach to safety event review, analysis, and response. They establish a process for peer reviews of serious safety events that uses a just culture algorithm. The process includes determining the timing of the review relative to the event, who will be involved, and how findings from the review will be communicated. Similarly, the governance structure of high-performing systems is responsible for establishing a process for quickly escalating and addressing safety events, as described previously. In addition, high-performing systems do not keep safety events and good catches behind closed doors. The governance structure supports transparent data sharing, and other data are shared at all levels, including with the board. One system reviews its good catches regularly and presents them to the board as a way to recognize individuals who prevent safety events and reinforce the behavior of reporting as a critical part of the system's culture.

Change Concept: Commit to Investing in Safety

Governance

High performers dedicate substantial human and financial resources to support safety. They consider safety as an important independent factor when evaluating return on investment, and proactively invest in workforce training and development, technology, and processes that support safety.

Common across the high-performing systems is a commitment to making investments in safety. As discussed previously, high performers prioritize doing the right thing for patients first and keeping them safe, such as through new tools or technologies, and then they look for ways to secure the needed financial support. High performers also invest in robust real-time patient care data reporting and analysis systems that support data-driven decision making about safety priorities. In addition, high performers invest in partnering with national or regional membership organizations that support healthcare quality improvement to access and monitor benchmarks against similar healthcare systems as part of their vision for excellence. Similarly, as discussed previously, the

role of patient safety event reporting systems is critical to system-level performance in safety and a robust safety culture. High-performing systems invest time and resources into exploring and implementing options that streamline the processes associated with event reporting, analysis, and response to ensure timely action.

High-performing systems recognize that providing safe and quality care and a positive patient experience are competitive business advantages. For example, a hospital in one of the high-performing healthcare systems redesigned their entire ED workflow to improve the patient and family experience, maximize the availability of physicians and nurses, and improve overall safety and quality. The result of this investment in time and resources was a notable improvement in the ED's reputation within its community. In addition, while all healthcare systems recognize the importance of return on investment (ROI) in terms of traditional metrics like profit, high-performing systems also integrate events that did not happen (i.e., harm avoidance) into their goals and acknowledge it as an ROI that cannot be explicitly monetized but is independently worthy of prioritization and investment. For example, they include measures such as estimated lives saved and harms avoided in their safety goals when this information is trackable and available (e.g., a reduction in failure to rescue events). These types of ROIs can be impactful for healthcare systems to share with the workforce and community, as they demonstrate transparency and vigilance toward safety.

High-performing systems make investments in safety beyond systems and processes. Systems also invest in hiring a workforce and training the existing workforce in safety, quality, and data analytics. In addition, high-performing systems provide compensation or protected time away from patient care for safety-related activities. For example, one healthcare system monitors physician relative value units at a group level, rather than an individual level, to facilitate the ability of physicians to engage in safety and quality improvement activities. Another system employs performance improvement advisors to lead improvement projects and engage the workforce based on a stakeholder analysis that identifies who needs to be involved in the project. They shared that a key lesson learned was clearly and proactively communicating the time that the workforce would need to participate meaningfully, so that the appropriate plans could be made to ensure that time is available.

Conclusion

The National Action Alliance is committed to the shared vision of safe care everywhere and zero preventable harm for all. In support of this vision, three high-performing healthcare systems (Houston Methodist, Mayo Clinic, and St. Luke's University Health Network) serve as real-world exemplars of how a commitment to safety culture, leadership, and governance serves as a foundation to achieving high performance in safety. The strategies, change concepts, and actionable practices observed during learning visits at each of these high-performing healthcare systems have been summarized into a framework that is the basis of the *Best Practices to Strengthen Safety Culture, Leadership, and Governance Change Package* (Appendix C). The intent of this work, along with other safety improvement resources and initiatives, is to offer healthcare systems actionable practices to support the goal of achieving quality and advancing patient and workforce safety on the journey to zero harm.

Appendix A. Hospital and Healthcare System Measures Reviewed

Exhibit 5. Data Sources for Hospitals and Healthcare Systems

Data Source Organization and File Name	Timeframe Represented by Data File	Variables Used for Analysis
CMS Provider Data Catalog – Complications and Deaths – Hospital	7/1/2020–6/30/2023	• Death rate for heart attack patients • Death rate for CABG surgery patients • Death rate for COPD patients • Death rate for heart failure patients • Death rate for pneumonia patients • Death rate for stroke patients • Pressure ulcer rate • Death rate among surgical inpatients with serious treatable complications • Iatrogenic pneumothorax rate • In-hospital fall with hip fracture rate • Postoperative hemorrhage or hematoma rate • Postoperative acute kidney injury requiring dialysis rate • Postoperative respiratory failure rate • Perioperative pulmonary embolism or deep vein thrombosis rate • Postoperative sepsis rate • Postoperative wound dehiscence rate • Abdominopelvic accidental puncture or laceration rate
CMS Provider Data Catalog – Complications and Deaths – Hospital	7/1/2020–3/31/2023	• Rate of complications for hip/knee replacement patients

Data Source Organization and File Name	Timeframe Represented by Data File	Variables Used for Analysis
CMS Provider Data Catalog – Healthcare Associated Infections – Hospital	10/1/2022–9/30/2023	• Central line-associated bloodstream infection (Intensive Care Unit [ICU] and select wards) • Catheter-associated urinary tract infection (ICU and select wards) • Surgical site infection (SSI) - Colon surgery • SSI - Abdominal hysterectomy • MRSA bacteremia • Clostridium difficile
CMS Provider Data Catalog – Hospital Consumer Assessment of Healthcare Providers and Systems	10/1/2022–9/30/2023	• Nurse communication - star rating • Doctor communication - star rating • Staff responsiveness - star rating • Communication about medicines - star rating • Discharge information - star rating • Care transition - star rating • Cleanliness - star rating • Quietness - star rating • Overall hospital rating - star rating • Recommend hospital - star rating • Summary star rating
CMS Provider Data Catalog – Hospital General Information, Published 4/24/24	Dates vary by measure	• Hospital overall rating
CMS Medicaid.gov – October 1, 2024, Exception List	Published September 11, 2024	• Percentile percent Medicare Supplemental Security Income days of inpatient days
AHRQ Compendium of U.S. Health Systems	2022	• Healthcare system name
Leapfrog Grades	Fall 2024	• Leapfrog Hospital Safety Grade
American Hospital Directory, Hospital Profiles	2024	• Number of licensed beds
Center for Healthcare Quality and Payment Reform, Saving Rural Hospitals	November 2024	• Rural hospital indicator on high performers

Appendix B. TEP Meeting Attendees

Exhibit 6. Healthcare System Attendees

Healthcare System	Attendee Name	Attendee Title
Houston Methodist	Shawn Tittle, MD, MBA	Senior Vice President and System Chief Quality Officer, Safety, Quality and Service, Houston Methodist
Houston Methodist	Ana McCauley, MPH, PMP	Project Director to the Senior Vice President, Safety, Quality, and Service, Houston Methodist
Houston Methodist	Kami Walker, JD, RN, CPHQ	Vice President, Safety, Quality and Service, Houston Methodist
Houston Methodist	Apoorv Broor, MD, MBA	Chief Medical Officer and Chief Quality Officer, Houston Methodist Baytown Hospital
Houston Methodist	Matthew Richards, DNP, RN	Director of Emergency Department, Houston Methodist Baytown Hospital
Mayo Clinic	Pauline Byom, MBA	Administrator, Interim Vice Chair, Quality and Operations, Mayo Clinic
Mayo Clinic	Kate Nesbitt, MS	Administrator, Patient Safety, Mayo Clinic
St. Luke's University Health Network	Donna Sabol, RN, MSN, CPHQ*	Senior Vice President and Chief Quality Officer, St. Luke's University Health Network
St. Luke's University Health Network	Diana Tarone, MSN, MBA, RN	Senior Network Director, Quality, St. Luke's University Health Network
St. Luke's University Health Network	Michael Sabol, DO	President of the Network's Medical Staff, St. Luke's University Health Network
St. Luke's University Health Network	Theresa Hosking, MSN, RN	Vice President, Patient Care Services, St Luke's Hospital - Miners Campus
St. Luke's University Health Network	Christopher Roscher, MD	Chairman, Department of Anesthesiology, St. Luke's University Hospital - Bethlehem Campus

*Virtual attendee.

Exhibit 7. Federal Partner Attendees

Organization	Attendee Name	Attendee Title
Agency for Healthcare Research and Quality	Craig Umscheid, MD, MS	Director, Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality	Jade Perdue-Puli, MPA	Senior Advisor to the Director for the Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality	Erin Grace, MHA	Deputy Director, Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality	Melissa Bhatnagar, MPA	Senior Staff Service Fellow, Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality	Jonathan Bakdash, PhD**	Social Science Analyst, Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality	Monika Haugstetter, MHA, MSN, RN	Health Scientist Administrator, Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality	Margie Shofer, MBA, BSN**	Director, General Patient Safety Division, Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality	Andrea Timashenka, JD	Director, Patient Safety Organization Division, Center for Quality Improvement and Patient Safety
Centers for Disease Control and Prevention	Arjun Srinivasan, MD*	Deputy Director, Program Improvement, Division of Healthcare Quality Promotion
Centers for Medicare & Medicaid Services	Traci Archibald, MBA*	Acting Director, iQuality Improvement and Innovation Group
Indian Health Service	Michelle Livingston, MSN, RN*	Patient Safety Coordinator, Division of Patient Safety and Clinical Risk Management
Veterans Health Administration	Ed Yackel, DNP*	Executive Director, National Center for Patient Safety

*Virtual attendee.

**Hybrid attendee.

Exhibit 8. Private Partner Attendees

Organization	Attendee Name	Attendee Title
American Hospital Association	Akin Demehin, MPH	Vice President, Quality and Safety Policy
ECRI	Shannon Davila, MSN, RN**	Executive Director of Total Systems Safety
Institute for Healthcare Improvement	Patricia McGaffigan, RN, MS*	Senior Advisor, Patient and Workforce Safety
Patients for Patient Safety	Marty Hatlie, JD	Director for Advocacy and Policy
Press Ganey	Tejal Gandhi, MD, MPH*	Chief Safety and Transformation Officer
Press Ganey	Carole Stockmeier, MHA*	Senior Vice President of Safety and Reliability Solutions
The Joint Commission	Elizabeth Mort, MD, MPH*	Vice President and Chief Medical Officer
The Leapfrog Group	Missy Danforth*	Senior Vice President, Health Care Ratings

*Virtual attendee.

**Hybrid attendee.

Appendix C. Change Package

NATIONAL ACTION ALLIANCE FOR PATIENT AND WORKFORCE SAFETY

Best Practices to Strengthen Safety Culture, Leadership, and Governance Change Package

Prepared for the Agency for Healthcare Research and Quality
Center for Quality Improvement and Patient Safety (CQuIPS)

by

Ripple Effect, Inc.

Prepared under Contract Number 47QRA22D008N

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NATIONAL ACTION ALLIANCE
for Patient and Workforce Safety

Contents

Introduction

Background

The National Action Alliance for Patient and Workforce Safety (National Action Alliance) is a collective effort of federal agencies and private partners, including patients and families, to improve the safety of patients and the healthcare workforce. Working together, the National Action Alliance catalyzes change by applying known harm reduction strategies, leveraging evidence-based tools and resources, and sharing best practices and lessons learned. The National Action Alliance's vision is **safe care everywhere and zero preventable harm for all**.

The National Action Alliance builds on the work of the National Steering Committee for Patient Safety (NSC), which in 2020 released the report, *Safer Together: A National Action Plan to Advance Patient Safety*.[1,2] The report is the result of the contributions and insights of 27 leading organizations that joined together as the NSC to develop a framework for improving patient safety and reducing harm to patients and healthcare workers. The National Action Plan (NAP) presents 17 recommendations that are organized into four foundational areas: (1) Culture, Leadership, and Governance; (2) Patient and Family Engagement; (3) Workforce Safety; and (4) Learning Health Systems.

Safety Culture, Leadership, and Governance serve as the foundation for safer healthcare. This change package builds upon the foundational work completed by the NSC. It identifies a menu of strategies, changes, concepts, and actions culled from high-performing healthcare systems for the purpose of sharing broadly with other healthcare systems in pursuit of zero harm.

Three high-performing healthcare systems were identified from publicly available safety and experience data: Houston Methodist (Houston, TX, and Baytown, TX), Mayo Clinic (Rochester, MN, and Eau Claire, WI), and St. Luke's University Health Network (Bethlehem, PA, and Coaldale, PA). On-site learning visits offered an opportunity to engage with leaders and staff and observe processes that demonstrate the operationalization of each system's safety culture, leadership, and governance. An appreciative inquiry approach was used to engage leaders and staff. This approach focused on system-driven interactions to glean insights into what contributes to the system's safety outcomes.

Acknowledgements

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AHRQ would like to express its sincere gratitude to the healthcare systems, their leaders, and many individuals who generously contributed their time, expertise, and experiences in developing this change package. In particular, AHRQ acknowledges the significant contributions of the three high-performing healthcare systems and their individual hospitals that shared experiences and best practices so that others could learn from their quality improvement journey:

- **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)

In addition, we would like to thank all the attendees of the July 2025 Technical Expert Panel (TEP). Participants included TEP members from the high-performing healthcare systems, as well as many thought leaders from the national patient safety community.

How To Use This Change Package

This change package summarizes the high-level strategies, change concepts, and actionable practices observed during learning visits to the three high-performing healthcare systems, which serve a clinically complex patient mix from urban, suburban, and rural areas. This change package serves as a menu of strategies, change concepts, and actions related to safety culture, leadership, and governance. The information provided is intended to support other healthcare systems on their zero-harm journey or those who are seeking to address specific gaps.

This change package does not represent a comprehensive review of all evidence-based safety practices related to safety culture, leadership, and governance; rather, it describes those gleaned from the high-performing healthcare systems. It is intended for use as a complementary resource with other national patient safety initiatives and improvement tools that address safety culture, leadership, and governance, such as the NAP Self-Assessment Tool, the CMS Patient Safety Structural Measure, and the Leapfrog Hospital Survey, among others. These tools may help healthcare systems identify opportunities for improvement for which the change package can offer suggested practices to implement and test using the system's preferred quality improvement methodologies.

The change package is arranged by three primary drivers of high performance in safety that are demonstrated by Houston Methodist, Mayo Clinic, and St. Luke's University Health Network:

1. The **safety culture** is a core value, created and sustained through purposeful actions.
2. **Leaders** embody, cultivate, and reinforce the safety culture.
3. **Governance** structures and strategic planning support safety.

While there is some overlap between actionable practices among the drivers, the focus of the overlapping practices differs under each driver. The safety culture driver describes system and workforce behaviors that result in a strong safety culture, the leadership driver describes specific leader behaviors that support high performance in safety, and the governance driver describes system structures and governing body behaviors that support safety. For example, under the safety culture driver, the actionable practice might refer to "participating" in a process, but under the leadership driver, the actionable practice might refer to "supporting and sustaining" the same process.

Exhibit 1 presents the theory of change that provides a framework for the practices presented.

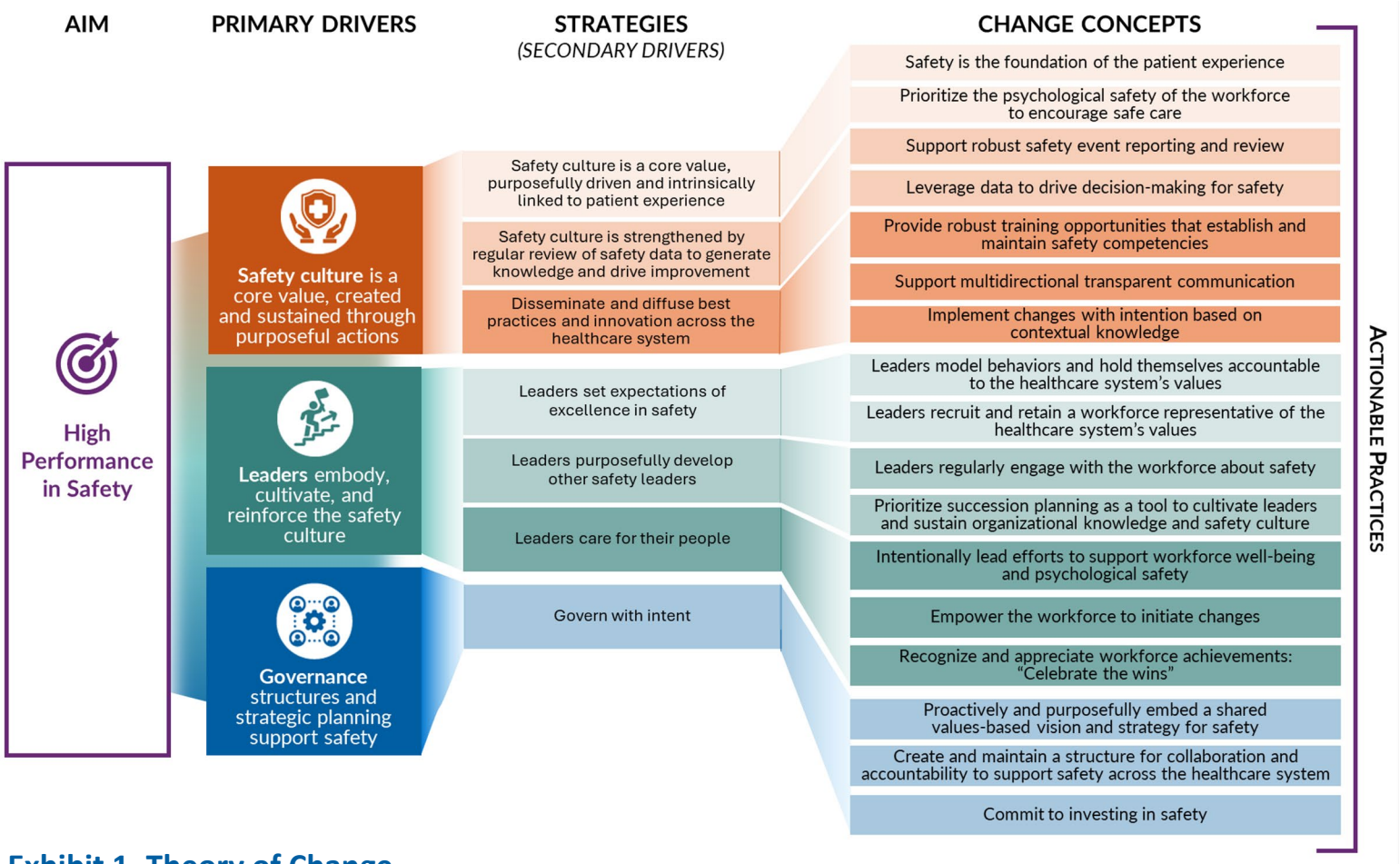

Exhibit 1. Theory of Change

As shown, the **primary drivers**—or factors that directly contribute to or primarily influence the achievement of the aim—center on the three areas of focus for this change package: healthcare system safety culture, leadership, and governance. **Strategies** enable the categorization of higher-level themes within each of the primary drivers. **Change concepts** provide broad ideas or approaches that have been demonstrated to be impactful in leading to improvements. For each change concept, specific, **actionable practices** guide healthcare systems with steps to test and implement towards safer care.

Throughout the document, selected actionable practices are presented in **bold font**. These represent actions that the high-performing healthcare systems identified as foundational to their success. Healthcare systems that are getting started on their quality improvement journey or are working to revamp their safety systems may wish to prioritize these actions in their change efforts.

Glossary

Terms Adapted from the National Action Plan:

- **Governance body:** The board of directors, or in healthcare systems without a board, the governing body that convenes to make strategic and operational decisions for the system.
- **Leader:** Any individual in a leadership position within a system, regardless of job title. Leaders can include hospital and healthcare system executives, administrative leaders, clinical leaders, division or department leaders, etc.
- **Leadership:** The action of leading a group of people or a healthcare system.
- **Senior leader:** An individual within a system who has decision-making responsibility for strategy and operations at the system level, often with the highest levels of authority (e.g., C-level executives; board of directors members).

Terms Defined by the Technical Expert Panel:

- **Best practice:** A safety culture, leadership, or governance practice gleaned from the high-performing healthcare systems that has demonstrated a positive impact on safety outcomes.
- **Dyad leadership model:** A collaborative co-leadership model where two leaders, typically a clinician and an administrator, share leadership and oversight.
- **Good catch:** A safety event that could have resulted in harm but did not reach an individual because it was identified and intervened upon by a healthcare worker. A good catch is a type of near miss.
- **Mission:** The healthcare system's purpose; what drives the healthcare system.
- **Near miss:** A safety event that could have resulted in harm but did not reach an individual because of chance or human intervention (i.e., a good catch).
- **Purposeful leader rounding:** Distinct from multidisciplinary rounding, purposeful leader rounding involves leaders engaging with the workforce, patients, and visitors on hospital units and other settings where the workforce and patients are present for the purpose of multidirectional information sharing,

problem solving, and fostering the safety culture. Leader rounds can be structured (i.e., involving the use of a framework or tool) or unstructured.

- **Safety event:** An incident or circumstance that could have resulted in harm (i.e., near miss or good catch) or did result in harm to a patient.
- **Shared accountability:** A collaborative approach to healthcare involving patients, the healthcare workforce, and healthcare leaders to mutually participate in and take responsibility for achieving patient-centered health outcomes.
- **Shared governance:** A collaborative management approach that allows employees to actively participate in the decision-making processes of their system. This model aims to enhance employee engagement and accountability, fostering a sense of ownership that can lead to improved work performance and ethical standards within the system.[3]
- **Tiered huddles:** Structured daily meetings that occur across multiple levels of leaders within a healthcare system to facilitate communication from the unit level to senior system leaders.
- **Triad leadership model:** A collaborative leadership model where three leaders, typically a physician, a nurse, and an administrator, share leadership and oversight.
- **Values:** Core cultural tenets that stand the test of time. They are enduring and steadfast and set the stage for the vision—the "North Star."
- **Vision:** The future state that describes where the healthcare system wants to go.
- **Workforce:** All members of the care team, not just clinical staff.

Primary Drivers

Primary Driver: The Safety Culture is a Core Value, Created and Sustained Through Purposeful Actions

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Safety culture is a core value, purposefully driven and intrinsically linked to patient experience.	Safety is the foundation of the patient experience.	High performers view safety as a key part of the patient experience. Patients and their loved ones are an essential part of the care team, and their feedback is incorporated into the design of safety processes and interventions.	• **Conduct multidisciplinary rounds and bedside shift reports to coordinate care team messaging to the patient and family.** • Engage in shared decision-making with patients and families. • Use purposeful leader rounding to engage patients and families and encourage collaboration, visibility, trust building, and problem-solving. • Narrate care processes to explain the purpose and rationale to patients and families. • Showcase patient stories and celebrate successes through multiple modalities and types of media, e.g., websites and social media. • Emphasize compassionate and responsive care through family advisory councils and patient stories. • Bring the voice of the patient into each quality, safety, and leadership meeting.
Safety culture is a core value, purposefully driven and intrinsically linked to patient experience.	Prioritize the psychological safety of the workforce to encourage safe care.	High performers prioritize the psychological safety of the workforce to ensure they feel safe to speak up and voice safety concerns. They focus on processes, and balance system and personal accountability when a safety event occurs. They recognize that workforce psychological safety allows a system to create and sustain a speak-up culture. When the workforce feels safe, they are empowered to deliver safe patient care.	• Encourage transparent safety reporting processes, while also establishing avenues for anonymous reporting of safety events. • Provide access to trained professionals for the workforce to have open conversations about their well-being. • Utilize peer support programs that can be proactively deployed to support the workforce in response to harm events. • Provide the workforce with opportunities and tools that make it easy to speak up. • Normalize a positive response to individuals speaking up. • Celebrate the workforce for speaking up at the system level. • **Use a systematic event review framework that focuses on process optimization over personal fault and balances personal and system accountability.**

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Safety culture is strengthened by regular review of safety data to generate knowledge and drive improvement.	Support robust safety event reporting and review.	High performers expect the workforce to report safety events/concerns and use structured methods to analyze events and drive improvement.	• **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.** • Conduct a structured review and analysis process on good catches to prevent future safety events. • Obtain input from the workforce involved in safety events as part of the structured process to review each safety event (e.g., Root Cause Analysis). • Develop an action plan from every safety event review and disseminate it across the system. • Include event reporting as a standing item in meeting agendas to facilitate communication and collaboration. • Maintain a hotline for patient-reported safety events/concerns. • Leverage electronic health record surveillance capabilities to alert potential safety events for clinical review and follow-up (real-time and retrospective). • Capture and share learnings from both failures and successes.
Safety culture is strengthened by regular review of safety data to generate knowledge and drive improvement.	Leverage data to drive decision-making for safety.	High performers use objective data to make safety decisions. They monitor data in close-to-real-time and present it in ways that can be operationalized through quality improvement activities.	• Develop and use data dashboards to transparently track baseline data and progress. • **Benchmark data internally and externally and establish standard metrics, definitions, and data sources that are shared across the healthcare system.** • **Maximize the use of real-time data and share data transparently to support clinical decision making.** • Use all available data to support structured quality improvement efforts.

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Disseminate and diffuse best practices and innovation across the healthcare system.	Provide robust training opportunities that establish and maintain safety competencies.	High performers offer multiple opportunities for competency-based training that is grounded in their values, including safety, quality, and patient experience. These competencies are consistently reinforced with the workforce, beginning with orientation.	• **Embed the healthcare system's values, including safety, in new employee orientation and reinforce through values-based training.** • Require annual safety competencies and training for the entire workforce. • Use simulation-based and hands-on training to develop and reinforce safety competencies. • Provide targeted training in response to identified failures to prevent recurrence. • Partner with local organizations and facilities that have training resources that can be shared to expand access to learning opportunities.
Disseminate and diffuse best practices and innovation across the healthcare system.	Support multidirectional transparent communication.	High performers create channels for open and transparent communication across all levels of the healthcare system, ensuring workforce and patient voices are heard and addressed. They use multiple modalities for real-time communication, both informal and formal, and consistently close the loop with timely feedback.	• Establish open communication with patients and families at admission and encourage engagement in care. • Embed patients and families in safety councils and advisory committees. • Leverage virtual meeting platforms, such as Microsoft Teams, to enable real-time, transparent communication related to safety across units/clinics, departments, and leadership teams. • Use daily management boards at the unit/clinic level for leaders to communicate safety priorities with the workforce and encourage staff input. • Create communication channels to collect workforce ideas, such as "Voice of Staff" tickets that are reviewed and responded to by leaders. • **Participate in 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).**

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Disseminate and diffuse best practices and innovation across the healthcare system.	Implement changes with intention based on contextual knowledge.	High performers leverage change management and implementation science principles to maintain an appropriate balance between standardization and planned adaptation to local needs. They approach the rollout of safety plans with clear intention, while actively seeking feedback from all interested parties and monitoring the results of changes.	• Start with small pilot tests and plan for broad dissemination once changes have been refined. • Recognize the need for standardized key processes across the system but incorporate phased implementation and planned adaptation based on local needs when appropriate. • Communicate the benefit of changes to stakeholders to gain buy-in. • **Make tests of change and results visible.** • Listen to late adopters and resistors to understand and resolve barriers to implementation. • Ensure physician champions are supported by quality and safety professionals.

Primary Driver: Leaders Embody, Cultivate, and Reinforce the Safety Culture

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Leaders set expectations of excellence in safety.	Leaders model behaviors and hold themselves accountable to the healthcare system's values.	High performers expect leaders to model safety behaviors and create pathways to ensure leaders are approachable and accountable for a culture of safety.	• **Make it acceptable for the workforce to fail and learn from failures—fail forward.*** • Develop and model humility, emotional intelligence, and critical self-analysis.* • **Take accountability for specific safety achievements of the healthcare system.*** • **Set and communicate expectations related to physical and psychological safety across the healthcare system for patients and the workforce.*** ***Indicates a leader-driven practice, rather than a system-driven practice***
Leaders set expectations of excellence in safety.	Leaders recruit and retain a workforce representative of the healthcare system's values.	High performers prioritize recruiting a workforce based on cultural fit. Job descriptions emphasize safety, and the workforce is held accountable for providing safe, high-quality care.	• **Establish an extensive vetting process for new leaders with multidisciplinary and multi-level interviews to ensure alignment with the safety culture.** • Provide resources to support workforce career advancement. • Ensure leaders fit into the culture of the healthcare system and manage out leaders that do not fit into the culture after giving them the resources and support to succeed.
Leaders purposefully develop other safety leaders.	Leaders regularly engage with the workforce about safety.	High performers actively support leaders to model the culture of safety through rounding and regular engagement with the workforce and patients.	• **Require and support regularly scheduled leader rounding with the workforce and patients focused on problem-solving, patient safety concerns, real-time reporting, and accountability.** • Support and sustain structured daily meetings that occur across multiple levels of leaders to facilitate communication from the unit to senior system leaders (i.e., tiered huddles). • Establish an escalating safety event review, analysis, and response process that quickly gets information to those who need it and hold leaders accountable for responding to events.

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Leaders purposefully develop other safety leaders.	Prioritize succession planning as a tool to cultivate leaders and sustain organizational knowledge and safety culture.	High performers intentionally assess leaders for cultural fit and develop leaders through mentorship and succession planning.	• **Evaluate individual alignment with values, strengths, and interests during regular workforce interactions to identify emerging leaders.** • **Intentionally develop current and future leaders through mentorship, coaching, and training with succession planning in mind.**
Leaders care for their people.	Intentionally lead efforts to support workforce well-being and psychological safety.	High performers recognize that well-being and psychological safety are fundamental to safe patient care. They also consider workforce well-being and safety key drivers to reduce burnout and turnover.	• Provide meaningful peer support for difficult situations encountered during clinical practice. • **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).** • Train the workforce to facilitate sensitive topic discussions. • Check on workforce well-being if performance issues are identified.
Leaders care for their people.	Empower the workforce to initiate changes.	High performers empower the workforce to identify opportunities and solutions for improvement across the healthcare system.	• **Maintain a system for transparent team communication at all levels**. • Empower the workforce with the autonomy and resources to resolve safety concerns for patients and staff. • **Provide mechanisms, such as employee engagement surveys, patient safety culture surveys, or 360-degree reviews, for the workforce to provide feedback about direct supervisors related to safety culture.**
Leaders care for their people.	Recognize and appreciate workforce achievements: "Celebrate the wins."	High performers have well-developed programs tied to their values that recognize workforce achievements and engagement in intentional and endurable ways.	• Recognize and appreciate the workforce for their achievements, including those related to the healthcare system's values, like safety.* • Establish various levels of recognition based on the types of recognition valued by the workforce. • Develop a clear peer nomination process for recognizing excellence in safety. • **Decrease barriers and burdens for the workforce to complete their work.*** • Encourage the workforce to submit safety projects for awards.* ***Indicates a leader-driven practice, rather than a system-driven practice**

Primary Driver: Governance Structures and Strategic Planning Support Safety

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Govern with intent.	Proactively and purposefully embed a shared values-based vision and strategy for safety.	High performers recognize safety as a core value critical to their patient-focused mission. The vision is clearly communicated and embodied across all levels, guiding short-term decisions and long-term strategic planning—leading to a strong, visible culture of 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.** • Establish a memorable, plain language slogan that speaks to the values inherent to the healthcare system. Develop the slogan with input from the board, workforce, leaders at all levels, and the community. • **Craft short- and long-term strategic plans that explicitly center the shared values, mission, and vision as specific areas of assessment and revisit them regularly.** • Align improvement projects and other initiatives with shared values and evaluate their success. • Use values to guide decision-making and prioritize resources. • Emphasize values visibly and consistently across the system in different ways, e.g., quality awards, values-based workforce recognition.

Govern with intent.	Create and maintain a structure for collaboration and accountability to support safety across the healthcare system.	High performers maintain a governance structure underpinning their safety program that supports values-based decision-making, collaboration, and accountability across the system. The governance structure facilitates the patient and workforce experience from the unit level, across disciplines and specialties, up to the governing board. The governance structure also provides a mechanism to disseminate and standardize safety practices across the healthcare system, while allowing for adaptation as needed to respond to varying local conditions. Clinical and administrative leaders are held accountable for collaborating on safety decision-making.	• **Continuously monitor performance and decrease barriers to safety and quality.*** • **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.*** • Pair clinical and administrative leaders in all areas (e.g., using a dyad or triad model) based on complementary individual strengths and weaknesses to ensure all necessary perspectives are considered in decision-making. • **Use healthcare system data to evaluate the effectiveness of safety governance and systems for their impact on safety, quality, and the patient experience.** • Begin governance body meetings with the voice of the patient, serious safety events, and good catches. • Implement a shared accountability model that empowers the workforce to actively participate in decision-making related to safety and quality, e.g., shared governance. • Recruit inspirational safety champions to serve within the governing body. • Prioritize safety competencies for all members of the workforce from the board to the bedside. • Centralize system-wide safety, quality, patient experience, and data analytics experts partnered with trained hospital-based "boots on the ground" to ensure system-wide alignment of efforts. • Establish processes to conduct peer review of serious safety events. • Establish an escalating safety event review, analysis, and response process that quickly gets information to those who need it to take action and hold leaders accountable for responding to events. • Use stakeholder analysis to identify who to involve in problem-solving and effectively leverage expertise. • Share safety events, quality concerns, and best practices across the system through the formal committee structure, learning networks, and the use of common metrics. • Embed the community in the structure for safety and collaboration (e.g., invite volunteers, patient and family advisory council members, patients, and community members to serve on safety committees). ***Indicates an action taken by the governance body***

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Govern with intent.	Commit to investing in safety.	High performers dedicate substantial human and financial resources to support safety. They consider safety as an important independent factor when evaluating return on investment, and proactively invest in workforce training and development, technology, and processes that support safety.	• **Provide funding for robust real-time patient care data reporting and analysis systems, benchmarked to similar healthcare systems. Purchase data visualization tools to ensure data is usable by the workforce and can be used to support decision-making.** • Recognize that safety, quality, and patient experience are competitive business advantages. Value harm avoidance as an independent return on investment worthy of prioritization. • Budget for trained safety, quality, and analytics professionals. • Provide compensation or protected time away from patient care for quality and safety-related activities, e.g., clinical ladder, administrative hours. • **Invest in patient safety event reporting systems that streamline the event reporting process and allow for faster data analysis and response.**

References

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