



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

# Making Safety a Core Value: Building the Foundation

**NAA National Webinar**

January 27, 2026

# Housekeeping Instructions

- This webinar will be recorded and available for viewing on the [NAA website](#)
- We invite you to use the “Chat” function to engage with and ask questions of speakers throughout the webinar
- Closed Captioning (CC) is available
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# Thank You for Your Commitment to Advance Patient and Workforce Safety!



Martin J. Hatlie, JD  
Founding Member  
Director, Policy and Advocacy  
Patients for Patient Safety US

# Safe Care Everywhere Zero Preventable Harm for All

## Total Systems Approach to Safety Informed by Safety Self-Assessments

Strengthen  
safety  
competencies

Safety by  
design

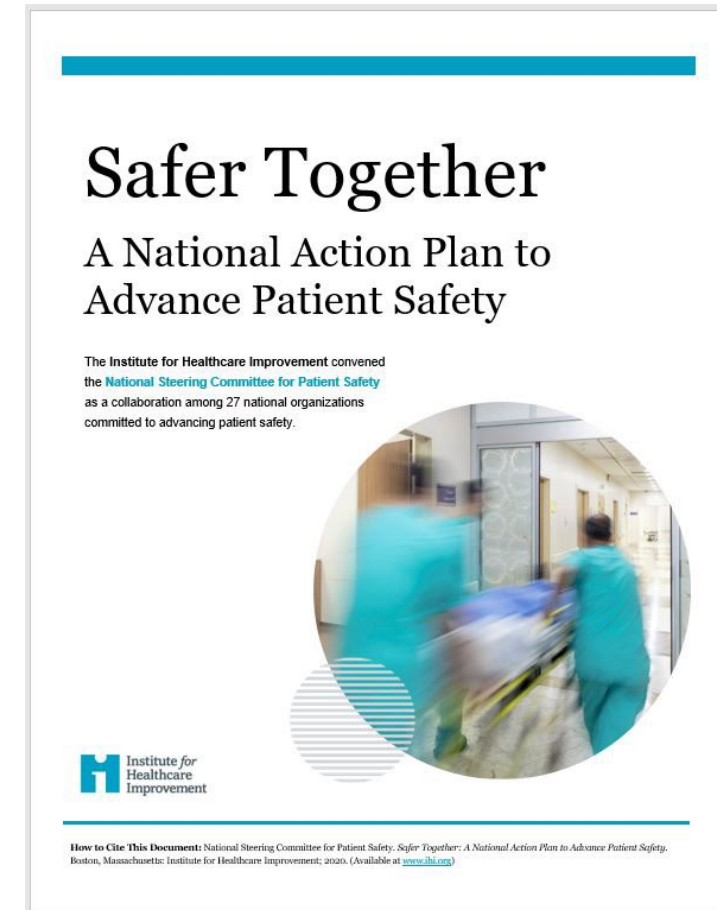
Empower the  
patient's voice

Learning and Research Network

1. Advance Organizational Safety Strategies Using Safety Self-Assessments
2. Empower the Patient's Voice in Safety Strategy
3. Support Healthcare Workforce by Making Healthcare Safer by Design
4. Support Healthcare Workforce by Strengthening Safety Competencies
5. Facilitate Learning and Research Network

# Four Foundational Areas of the National Action Plan for Patient Safety

- **Culture, Leadership, Governance**
  - Ex: Regular safety culture surveys
- **Patient and Family Engagement**
  - Ex: Actively engaged PFACs
- **Workforce Safety**
  - Ex: Explicit worker safety strategy
- **Learning Healthcare Systems**
  - Ex: Defined safety competencies for all workers



# CMS Patient Safety Structural Measure (PSSM)

PSSM Domain	Example PSSM Specifications
<b>Domain 1:</b> Leadership Commitment	<ul style="list-style-type: none"><li>• C-suite oversees <u>safety self-assessment</u></li></ul>
<b>Domain 2:</b> Strategic Planning	<ul style="list-style-type: none"><li>• Commitment to <u>“zero preventable harm”</u></li></ul>
<b>Domain 3:</b> Culture of Safety	<ul style="list-style-type: none"><li>• Hospital conducts <u>hospital-wide culture of safety survey</u></li></ul>
<b>Domain 4:</b> Transparency	<ul style="list-style-type: none"><li>• Hospital has a <u>communication and resolution program</u>, such as AHRQ’s CANDOR toolkit</li></ul>
<b>Domain 5:</b> Patient Engagement	<ul style="list-style-type: none"><li>• Patient and Family Advisory Council (<u>PFAC</u>) that provides input on safety-related activities</li></ul>

<https://qualitynet.cms.gov/pch/measures/safety>

# Best Practices of High-Performing Healthcare Systems

**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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Submitted to:  
Agency for Healthcare Research and Quality

Authored by:  
American Institutes for Research  
Subcontractor to Ripple Effect Communications, Inc.

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**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 (CQIPS)  
by  
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Prepared under Contract Number 47QRA22D008N

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

# Safety Culture is a Core Value

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

# Questions to Run On

- **What actions are you hearing from high performers that are most exciting?**
- **What are actionable takeaways from our presenters today?**

# Speaker Welcome



**Shawn Tittle, MD, MBA**

Senior Vice President and System Chief  
Quality Officer, Houston Methodist



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

Administrator–Mayo Clinic Quality, Mayo Clinic



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

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

# Safety as the Foundation: Houston Methodist

## AHRQ/Ripple Effect

Shawn Tittle, MD, MBA

January 2026



# THE VISION FOR THE SECOND CENTURY

Houston Methodist will set a new standard for leading academic medical centers through

**unparalleled safety, quality, service, AND innovation.**





YESTERDAY...



OUR MISSION

To provide high quality, cost-effective health care that delivers the best value to the people we serve in a spiritual environment of caring in association with internationally recognized teaching and research.



Impacting the Houston Community and Beyond



Groundbreaking Research



Great Place to Work

Research and Innovation

TO TODAY...



My pleasure!

Nationally Recognized for Quality and Service

INTEGRITY

COMPASSION



VALUE

CONSUMERISM TRENDS

ACCESS



TRANSPARENCY

ACCOUNTABILITY

Research

RESPECT

Convenience

EXCELLENCE



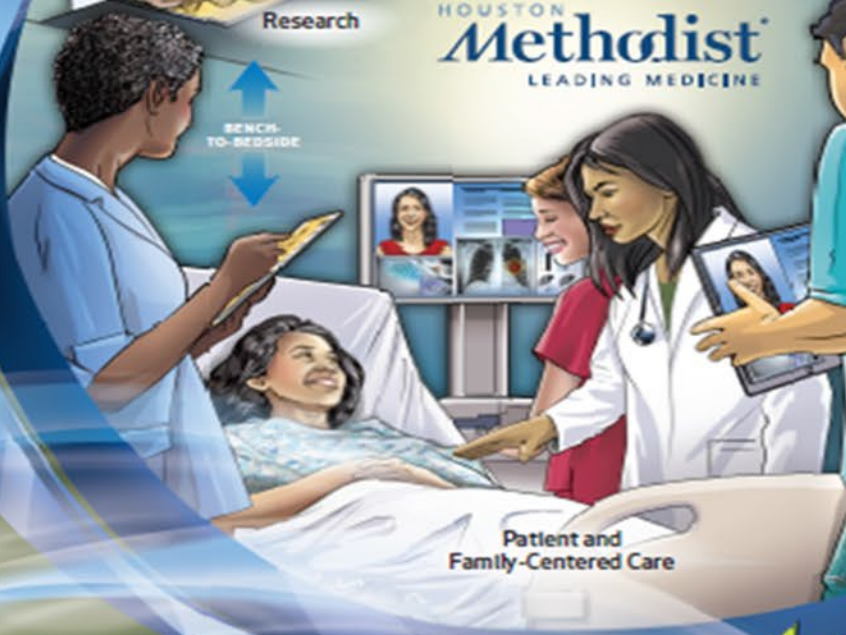
Population Health



Education

HOUSTON Methodist LEADING MEDICINE

BENCH-TO-BESIDE



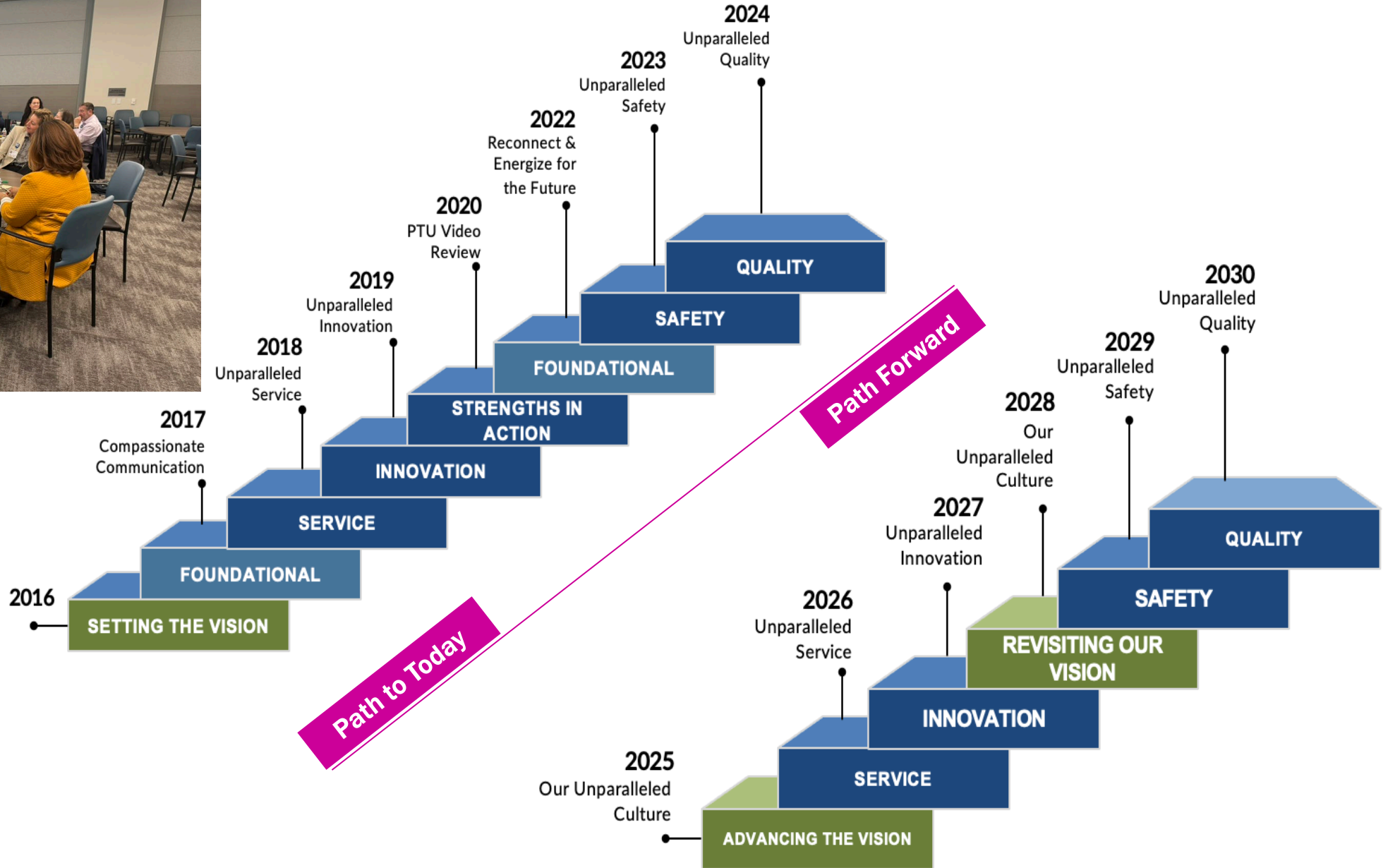
Patient and Family-Centered Care

TO AN UNPARALLELED TOMORROW...

CONTINUOUS IMPROVEMENT



# Pathway to Unparalleled Multiyear Plan



# Voice of the Patient

- First item in some high-level meetings
- Safety-focused
- Opening event in the annual Houston Methodist Safety and Quality Symposium

# Serious Safety Events

- Committee chaired by the system chief quality officer
- All are presented to the board of directors with case write-ups and action plans

# Good Catch

- First order of business at board-sponsored quality meetings
- Certificates and awards
- Annual luncheon celebrating award recipients
- Annual Greatest Catch award

# SQSS

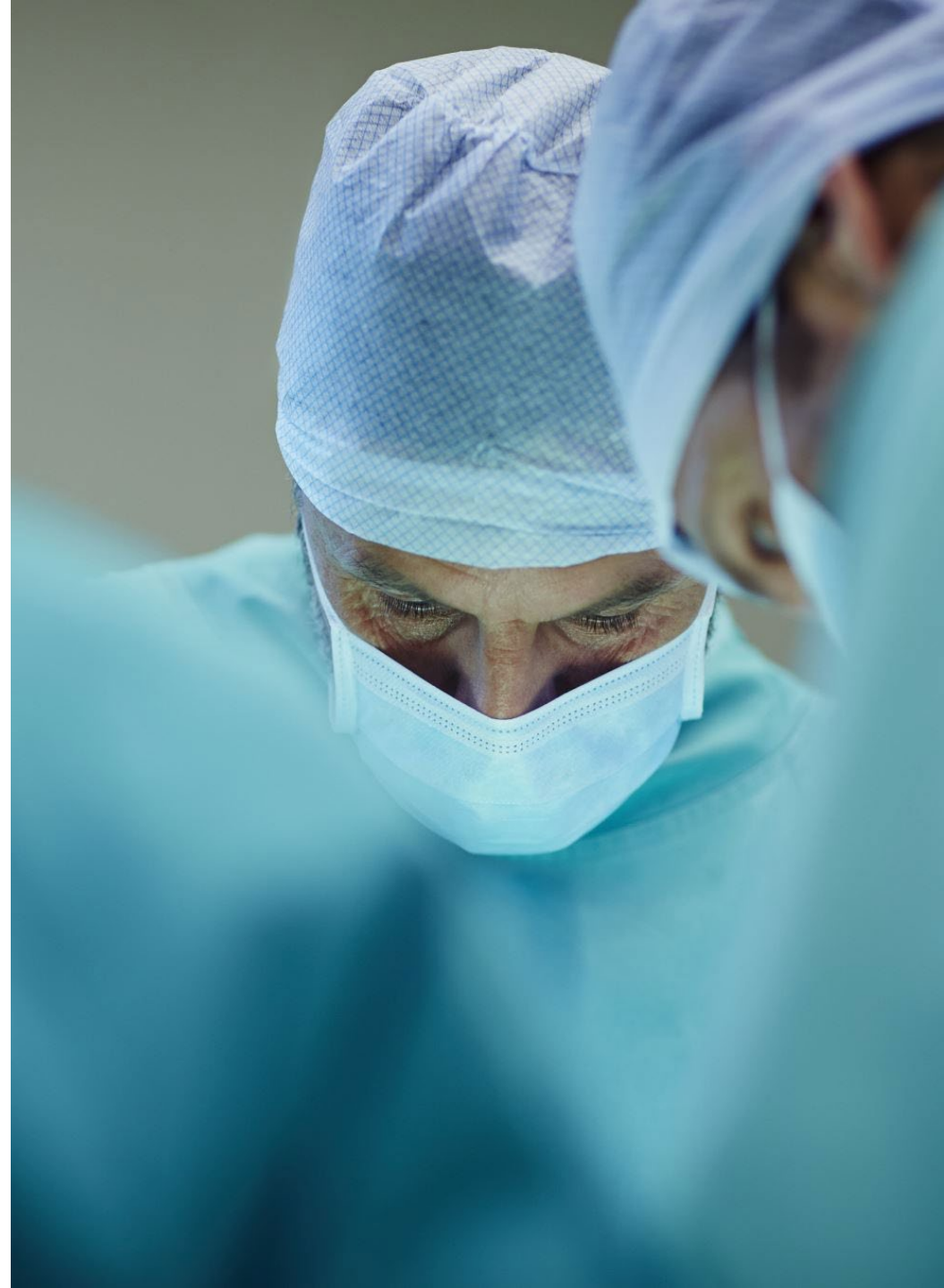
Safety, Quality & Service



# LIVING A CULTURE OF SAFETY

BEHAVIORS AND ACTIONS

PAULINE BYOM, MBA, CPHQ, FHIMSS



# WHY ARE WE HERE?

- **Safety is Everyone's Job (Even on Your 'Bad Hair Days')**
- Safety doesn't live in a policy
- It lives in everyday decisions
- And sometimes... awkward conversations



# THE NEAR MISS THAT ALMOST WASN'T

## What Happened

Something feels off

Everyone notices

No one says anything

*Later:* “We should’ve said something”

## Barriers to Speaking Up

Fear of being wrong

Fear of consequences

Time pressure

“Someone else has this”

## Safety in Action

A concern is raised

The response is supportive

Learnings are shared

Trust grows

*We replay it in our heads like a Netflix series we didn't want to binge.*

*You don't need a leadership badge to prevent harm—just courage and maybe a deep breath.*

*People don't stop speaking up because they're wrong—they stop when nothing happens.*

# HOW PATIENTS VIEW SAFETY OF CARE AT MAYO CLINIC

The physical environment and care teams' actions and communications are critical to a patient feeling safe. Mayo Clinic can increase a patient's sense of safety through the presence of security staff, hygienic practices, and a care team that is well trained in responsiveness and attentiveness.

	Physical Environment	Care Team Actions	Care Team Communication
Indicates Safety	✓ Entrance security, cleanliness, and the presence of staff available to support	✓ Care teams that pay attention, maintain good hygiene, and verify patient identities	✓ Making eye contact, giving the patient full attention when listening to their concerns, and asking patients if they are comfortable
Undermines Safety	× About half of patients have noticed physical aspects that indicate safety is not a priority × Inconsistent security, long distance from parking lot to entrance, lack of lighting or windows, or lack of security in the parking lots/garages	× Inattentiveness such as long delays in answering call buttons or failure to check in regularly × Unhygienic practices, rushing care, and poor communication	× When a clinician or care team fails to provide detailed explanations and appear to be disengaged, rushed, or not listening



# MAKING COMMITMENT VISIBLE

ENABLING STRUCTURES





**Keep It Going – A Leadership Imperative**  
**Donna Sabol, MSN, CPHQ**  
**Senior VP, Chief Quality Officer**



# Leaders Set Expectations of Excellence in Safety

## Leadership Principles

1. People and Relationships—Keystone of our culture
2. Leadership—Most important element of business, highest demand, short supply
3. Continuously strengthen the Culture of Safety
4. Integrity—Maintain transparent, accountable management
5. Simplicity—Flat structure; promote effectiveness/efficiency
6. Integration—Seamless system of care delivery



# Leaders Care for Their People

## Leaders Create Psychological Safety

Success requires risk-taking. Will naturally have wins and failures.

It's okay to make mistakes—own them & learn from them.

Strong mentorship and succession planning.

Speak truth to power— Value candor  
Productive disagreement  
Free exchange of ideas

Leadership visibility— Proactive inquiry  
Express appreciation  
Acknowledge opportunities

Zero tolerance of disruptive behaviors

The metric—Staff Engagement



# Leaders Care for Their People

## Gratitude – Brevity – Focus

1) Celebrate Successes

2) Keep it Real

Standing Agenda Item

Daily Rounds

3) Timely Feedback

Loop closure



### A Frosty Little Tidbit...

When you see that medical equipment is broken or not functioning properly please take it out of service and notify the appropriate department to fix or replace it.



# Questions and Answers

# Share With Us!

## Based on what you have learned today:

- What most excites you about what you heard?
- What are 1–2 key actionable takeaways?

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

# Thank You!

Announcing the Next NAA Monthly National Webinar

**Using Data for Real-Time Learning, Reporting, and Review**

Tuesday, March 10, 2026 (3–4 p.m. EST)

Register here – <https://www.ahrq.gov/action-alliance/webinars/index.html>

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