

C A S E S T U D Y

# Designing Reliability That Scales

How a Public Health System Embedded Safety, Learning,  
and Accountability Through Growth

C L I E N T

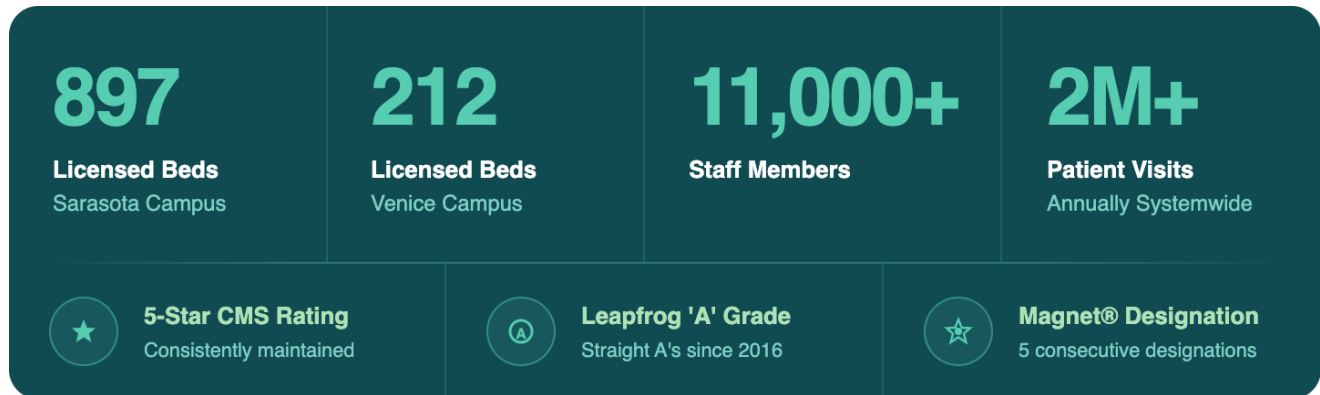
**Sarasota Memorial Health Care System**

**beterra** →

ABOUT THE CLIENT

## Sarasota Memorial Health Care System

Sarasota Memorial Health Care System (SMH) is one of the largest public health systems in Florida and a regional referral center serving Sarasota and Manatee counties. Founded in 1925 as a modest 32-bed community hospital, SMH has grown into a comprehensive, full-service health system with two hospital campuses, two freestanding emergency rooms, and a comprehensive network of outpatient centers, urgent care clinics, and physician practices.



The system's flagship Sarasota campus features an 897-bed acute-care hospital, as well as the Brian D. Jellison Cancer Institute Oncology Tower, Cornell Behavioral Health Pavilion, Rehabilitation Pavilion, and Kolschowsky Research and Education Institute, and is the only hospital in Sarasota County providing trauma services, obstetrical services, pediatrics, neonatal intensive care, and behavioral health services for patients of all ages. In 2021, SMH opened its second acute-care hospital in Venice with 110 private rooms and a full range of specialties to serve south Sarasota County. In 2024, the Venice campus doubled in size to 212 beds to meet the needs of the growing community. The health system also includes a skilled nursing facility.

Governed by a nine-member elected Sarasota County Public Hospital Board, SMH is directly accountable to the community it serves. With 11,000 staff members, it is Sarasota County's largest employer. The system is powered by 2,500 physicians and advanced practice providers and records more than two million patient visits annually.

## EXECUTIVE SUMMARY

High reliability in healthcare is often seen as a technical effort: checklists, training, reporting systems, and metrics. Sarasota Memorial Health Care System (SMH) demonstrates a more robust perspective. Their experience shows that achieving reliability at scale requires deliberate design and is rooted in leadership expectations, governance, workforce development, and daily operations. As a public health system serving a rapidly growing region, SMH has expanded facilities, services, and workforce while maintaining high standards for quality and safety.

The latest Safety Culture Survey achieved an 84% response rate across the system, surpassing national benchmarks and showing improvements in all areas from previous years. This high participation indicates psychological safety, trust in leadership, and a workforce willing to give honest feedback, believing it will lead to positive change. For SMH, these results suggest that safety and feedback systems are working well, learning continues, and safety standards are maintained, even as operational complexity grows.

84%

Safety Culture Survey response rate —  
**surpassing national benchmarks** with  
year-over-year improvement in all areas

## The Context: Growth, Public Accountability, and the Stakes of Reliability

Sarasota Memorial Health Care System occupies a special place in healthcare. Governed by a publicly elected Hospital Board, SMH is directly accountable to the community it serves. Safety, quality, access, and stewardship remain top priorities, guided by public expectations and reinforced at the highest levels of governance.

In recent years, SMH has significantly expanded through new hospital openings, service line growth, and increased care for an aging population. This rapid growth presents operational challenges and risks. Leaders understand that scaling quality and safety as the organization expands requires more than policies, audits, or metrics. It demands well-designed systemwide approaches to ensure reliability amid growing complexity.

## Leadership Reframe: Safety as an Expectation

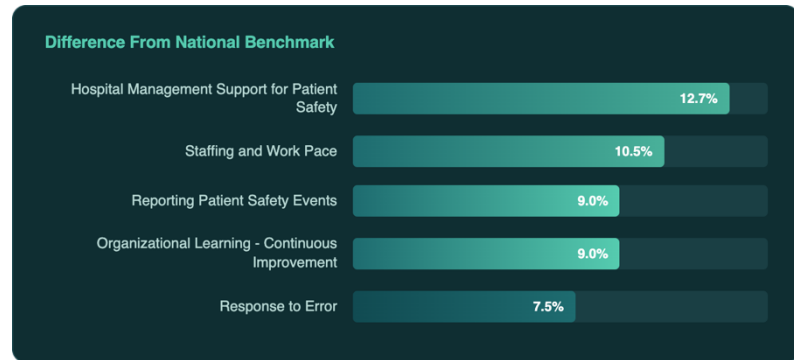
According to Quality and Risk Management Executive Director Cheryl Roberts, RN, MS, CPHQ, CPHRM, CPPS, these are not aspirational goals or departmental responsibilities. They are expectations embedded in leadership behavior and reinforced through governance.

“Maintaining our five-star CMS rating and Leapfrog ‘A’ is not a quality department goal. It’s an expectation of every leader in the organization. Everyone has a role to play.”

— Cheryl Roberts, RN, MS, CPHQ, CPHRM, CPPS — Executive Director, Quality and Risk Management

This mindset is reinforced by a system-wide strategic plan, clearly articulated standards of behavior, and leadership accountability that remains steadfast even when results are strong.

Staff perceptions of leadership mirror these expectations. Leadership commitment is shown through ongoing investments in staff development. Tuition reimbursement, specialty and board certifications for physicians, and professional growth opportunities across disciplines are genuine investments in the team, not mere benefits. The success of these initiatives is reflected in the Culture of Safety results, which surpass national benchmarks in key areas closely linked to leadership actions, such as Hospital Management Support for Patient Safety, Staffing and Work Pace, Reporting of Patient Safety Events, Organizational Learning and Continuous Improvement, and Response to Error. These areas improve through leaders' consistent emphasis on priorities, resource allocation, and effective responses when risks are identified.



## Changing Perceptions

For some, risk management in healthcare can be viewed with fear. Staff may worry that reporting a near-miss or error means “writing someone up.” SMH tackles this head-on with the first question asked during an investigation.

*“In every root cause analysis, we start by saying this is a learning process. Ninety to ninety-five percent of the time, we identify a process that can be improved, rather than simply attributing the issue to an individual issue.”*

— Cheryl Roberts, RN, MS, CPHQ, CPHRM, CPPS

Changing this perception requires more than education. It calls for a redesign of how the organization responds when things go wrong. SMH applies Just Culture principles by shifting investigations away from blame and toward system conditions, human factors, and process reliability. Leaders reduce reliance on memory by implementing forcing functions, checklists, and standardized workflows, especially within the electronic medical record. The goal is to systematize and standardize processes, removing rough edges so clinicians can concentrate on what they do best: providing care to the patient right in front of them.

## The Signal: A Surge in Reporting

One of the clearest signs that community trust exists at SMH is its strong culture of reporting. Leaders see reporting volume not as a sign of failure but as proof of psychological safety and organizational growth. The latest Culture of Safety Survey results (which are +9% above the national average for reporting patient safety events) reinforce this message. High participation shows a shared belief that speaking up matters and that leadership will respond appropriately. “Every report is an opportunity to learn,” Roberts said. “The year-over-year improvement indicates we are making good use of those opportunities.”

## Trust Through Transparency

Trust with patients, families, and staff is further strengthened by formalizing adverse event disclosure and support processes. SMH recently participated in the PACT Collaborative, which focuses on implementing systems to ensure timely communication, peer support, and learning after adverse events or unexpected outcomes.

Multidisciplinary teams review cases together. The focus is on compassion, transparency, clarity, and continuous improvement. “If we made a mistake, we admit it,” Roberts explained. “We share what we’ve learned, what changes we’re implementing, and how we’ll prevent it from happening again.”

This approach builds trust within the organization and with the community SMH serves.

*“Our goal is to demonstrate through consistent action that every patient and every family matters. We are committed to learning from the past and moving forward with integrity, transparency, and compassion.”*

— David Evans, Chief Legal Officer

## Safety as a Shared Ownership

A key strength of SMH’s culture is the high level of engagement among physicians, nurses, and allied health professionals. Safety and quality are collective responsibilities shared throughout daily clinical practice, not owned by any single role or department.

Physicians view reliability improvement efforts as practical support for delivering high-quality care. Clear expectations, uniform standards, and transparent risk responses enable clinicians to confidently focus on diagnosis and treatment, knowing the system supports learning from challenges. Physician leaders actively shape safety and quality initiatives, participating in nearly 20 specialty-focused quality and safety committees. They set priorities, review cases, and translate evidence into practice rather than merely being informed after decisions.

*“All of our physicians are board-certified and join our organization with a clear expectation: we set an exceptionally high bar for patient safety and quality. Every physician plays an active role in achieving this standard. Many voluntarily dedicate their time to serve on department-specific Quality Improvement Committees, helping to drive meaningful progress across our system. Our Medical Staff recognizes that this facility is an outstanding place to care for patients because we collectively uphold the highest standards of quality, and that responsibility is shared by everyone.”*

— James Fiorica, MD — Chief Medical Officer, Sarasota Memorial Health Care System

Nursing excellence remains strong. SMH has earned the Magnet designation for nursing excellence five consecutive times over 20-plus years, demonstrating that safety, professional

accountability, and shared governance are embedded in routine work and not dependent on individual leaders. Nursing governance elevates bedside voices, promotes accountability at the unit level, and fosters continuous improvement as a core professional duty.

At SMH, allied health professionals, including pharmacy, rehabilitation, behavioral health, and ancillary services, fully participate in safety and quality initiatives. Interdisciplinary committees ensure insights from across the care continuum influence system design.

## Systemization: Making Reliability Scalable

As SMH expands to multiple hospitals and ambulatory sites, leaders prioritize system standardization while maintaining clinical expertise. Risk and quality leaders are aligned by clinical domain, facilitating consistent collaboration with frontline teams across campuses. This structure allows the team to scale consistently across the entire integrated regional healthcare delivery system.

Root cause analyses regularly involve leaders from various sites, ensuring lessons learned in one location are applicable across the system. Policies and procedures are deliberately standardized to minimize variation and confusion, especially during rapid growth.

SMH also updated its incident reporting system in late 2024, which enhanced usability, transparency, and feedback. This upgrade reinforced staff confidence that speaking up prompts action.

## A Different View on Outcomes

SMH’s culture of strong safety is supported by publicly available quality and patient safety results from multiple campuses. State-reported data show solid performance on key harm prevention indicators, such as healthcare-associated infections and readmissions, with outcomes consistently meeting or surpassing expectations relative to state and national benchmarks. This high performance is evident throughout the entire system, demonstrating that SMH’s reliability is embedded in the system.

Patient experience measures also reflect this alignment. Both campuses outperform state and national averages in overall hospital ratings, and 15-day readmission rates are lower than expected, indicating effective care coordination, communication, and frontline execution.

These outcomes serve as external validation that the organization’s leadership accountability, system standardization, workforce capability, and safety culture lead to reliable patient and family results.



## KEY TAKEAWAYS

Sarasota Memorial Health Care System's experience provides practical lessons for organizations aiming for high reliability amid growth:

01

### Reliability Must Be Intentionally Designed

Psychological safety, reporting systems, and learning processes require deliberate structure and reinforcement. High reliability is not assumed — it is built.

02

### Safety Culture Endures Through Leadership Behavior

Expectations should be visible, consistent, and reinforced even when results are strong. Culture is shaped by what leaders prioritize every day.

03

### Transparency Enhances Trust and Credibility

Open communication with patients, families, and staff about adverse events and improvement actions strengthens organizational integrity.

04

### Standardization Supports Growth

Growth is sustainable through standardized systems designed to support human performance. Scaling quality requires eliminating variation, not adding complexity.

Roberts reflected, “A strong safety culture exists when people feel safe speaking up, are supported when issues arise, and trust that learning leads to real change.”

For SMH, designing scalable reliability has become a strategic priority. As the system expands, safety, learning, and accountability grow with it.

# About Beterra

Beterra is a healthcare technology company focused on building tools for safety and quality management.

Our solutions help clients accelerate improvement via collection, analysis, sensemaking, and safety and quality data utilization.

Explore our website at [www.beterra.com](http://www.beterra.com) or Contact us at [hello@beterra.com](mailto:hello@beterra.com)