Quick Start Guide:
Patient Safety Structural Measure

As part of the FY2025 final rule, CMS is requiring hospitals participating in the Hospital Inpatient Quality Reporting (IQR) program to report on the Patient Safety Structural Measure (PSSM).

Why? Structural measures provide a way for hospitals to address a topic for which no outcome measure exists. CMS expects that by attesting to these measures, hospitals will develop evidence-based programs and processes to support improvements in high impact areas.

What? The Patient Safety Structural Measure is an attestation-based measure that assesses whether hospitals have a structure and culture that prioritizes safety as demonstrated by the following five domains: (1) leadership commitment to eliminating preventable harm; (2) strategic planning and organizational policy; (3) culture of safety and learning health system; (4) accountability and transparency; and (5) patient and family engagement. Hospitals will attest to whether they engage in specific evidence-based best practices in each domain. Each domain is worth one point, for a total of five (5) points. The hospital must meet the required number of elements within a domain to receive a point. CMS will not give partial credit within the domain.

How? The attestation-based Patient Safety Structural measure will be reported through the National Healthcare Safety Network (NHSN) platform. NHSN will be releasing additional details at a later date. This Quick Start Guide outlines the five domains and provides resources to assist hospitals as they evaluate activities and processes against each domain.

Domain 1: Leadership Commitment to Eliminating Preventable Harm

The senior leadership and governing board at hospitals sets the tone for commitment to patient safety. They must be accountable for patient safety outcomes and ensure that patient safety is the highest priority for the hospital. While the hospital leadership and the governing board may convene a board committee dedicated to patient safety, the most senior governing board must oversee all safety activities and hold the organizational leadership accountable for outcomes. Patient safety should be central to all strategic, financial, and operational decisions.

Attestation Statements
A. Our hospital senior governing board prioritizes safety as a core value, holds hospital leadership accountable for patient safety, and includes patient safety metrics to inform annual leadership performance reviews and compensation.
B. Our hospital leaders, including C-suite executives, place patient safety as a core institutional value. One or more C-suite leaders oversee a system-wide assessment on safety and the execution of patient safety initiatives and operations, with specific improvement plans and metrics. These plans and metrics are widely shared across the hospital and governing board.
C. Our hospital governing board, in collaboration with leadership, ensures adequate resources to support patient safety (such as equipment, training, systems, personnel, and technology).
D. Reporting on patient safety and workforce safety events and initiatives (such as safety outcomes, improvement work, risk assessments, event cause analysis, infection outbreak, culture of safety, or other patient safety topics) accounts for at least 20% of the regular board agenda and discussion time for senior governing board meetings.
E. C-suite executives and individuals on the governing board are notified within 3 business days of any confirmed serious safety events resulting in significant morbidity, mortality, or other harm.

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Resources

- Blueprint: Leading for Safety | American College of Healthcare Executives
- National Action Plan to Advance Patient Safety | IHI
- Governance of Quality Assessment Online Tool | IHI
- List of Serious Reportable Events | National Quality Forum
- Sentinel Event Policy | The Joint Commission

Domain 2: Strategic Planning and Organizational Policy

Hospitals must leverage strategic planning and organizational policies to demonstrate a commitment to safety as a core value. The use of written policies and protocols that demonstrate patient safety is a priority, and identifying goals, metrics and practices to advance progress is foundational to creating an accountable and transparent organization. Hospitals should acknowledge the ultimate goal of zero preventable harm, even while recognizing that this goal may not be currently attainable and requires a continual process of improvement and commitment. Patient safety and equity in care are inextricable and therefore equity, with the goal of safety for all individuals, must be embedded in safety planning, goal-setting, policy and processes.

Attestation Statements

A. Our hospital has a strategic plan that publicly shares its commitment to patient safety as a core value and outlines specific safety goals and associated metrics, including the goal of "zero preventable harm."
B. Our hospital safety goals include the use of metrics to identify and address disparities in safety outcomes based on the patient characteristics determined by the hospital to be most important to health care outcomes for specific populations served.
C. Our hospital implemented written policies and protocols to cultivate a just culture that balances no-blame and appropriate accountability and reflects the distinction between human error, at-risk behavior, and reckless behavior.
D. Our hospital requires implementation of patient safety curriculum and competencies for all clinical and non-clinical hospital staff, including C-suite executives and individuals on the governing board, regular assessments of these competencies for all roles, and action plans for advancing safety skills and behaviors.
E. Our hospital has an action plan for workforce safety with improvement activities, metrics, and trends that address issues such as slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, fire/electrical safety, and psychological safety.

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Resources

- The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents | AHRQ
- The CUSP Method | AHRQ
- TeamSTEPPS 3.0 | AHRQ
- Workforce and Workplace Violence Prevention | AHA
- Mitigating Violence in the Workplace | American Organization for Nursing Leadership
- HQIC Quarterly Disparities Reports
- Health Equity Action Plan | HQIN
- Quick Start Guide: Hospital Commitment to Health Equity Measure | HQIN
- Simple Strategies to Shape Organizational Infrastructure and Culture | HQIN
- Workplace Violence Assessment | HQIN
- Workplace Violence: Strategies for Reducing & Preventing a Rising Trend | HQIN
- High Reliability Leadership Learning Module Series: Module #4 | YouTube | HQIN
- High Reliability Leadership Learning Module Series: Bonus Module | YouTube | HQIN
- Healthy Work Design and Well-Being Program | CDC
- High Reliability | The Joint Commission

Domain 3: Culture of Safety & Learning Health System

Hospitals must integrate a suite of evidence-based practices and protocols that are fundamental to cultivating a hospital culture that prioritizes safety and establishes a learning system both within and across hospitals. These practices focus on actively seeking and harnessing information to develop a proactive, hospital-wide approach to optimizing safety and eliminating preventable harm. Hospitals must establish an integrated infrastructure (i.e., people and systems working collaboratively) and foster psychological safety among staff to effectively and reliably implement these practices.

Attestation Statements
A. Our hospital conducts a hospital-wide culture of safety survey using a validated instrument annually, or every two years with pulse surveys on target units during non-survey years. Results are shared with the governing board and hospital staff, and used to inform unit-based interventions to reduce harm.
B. Our hospital has a dedicated team that conducts event analysis of serious safety events using an evidence-based approach, such as the National Patient Safety Foundation's Root Cause Analysis and Action (RCA^2).

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Attestation Statements Continued

C. Our hospital has a patient safety metrics dashboard and uses external benchmarks (such as CMS Star Ratings or other national databases) to monitor performance and inform improvement activities on safety events (such as: medication errors, surgical/procedural harm, falls, pressure injuries, diagnostic errors, and healthcare-associated infections).

D. Our hospital implements a minimum of 4 of the following high reliability practices:
   1. Tiered and escalating (e.g., unit, department, facility, system) safety huddles at least 5 days a week, with one day being a weekend, that include key clinical and non-clinical (e.g., lab, housekeeping, security) units and leaders, with a method in place for follow-up on issues identified.
   2. Hospital leaders participate in monthly rounding for safety on all units, with the C-suite executives rounding at least quarterly, with a method in place for follow-up on issues identified.
   3. A data infrastructure to measure safety, based on patient safety evidence (e.g., systematic reviews, national guidelines) and data from the EMR that enables identification and tracking of serious safety events and precursor events. These data are shared with C-suite executives at least monthly, and the governing board at every regularly scheduled meeting.
   4. Technologies, including a CPOE system and BCMA system, that promote safety and standardization of care using evidence-based programs.
   5. The use of a defined improvement method (or hybrid of proven methods), such as Lean, Six Sigma, PDSA, and/or high reliability framework.
   6. Team communication and collaboration training of all staff.
   7. The use of human factors engineering principles in selection and design of devices, equipment and processes.

E. Our hospital participated in large-scale learning network(s) for patient safety improvement (such as national or state safety improvement collaboratives), shares data on safety events with these network(s), and has implemented at least one best practice from the network or collaborative.

Resources

- Survey on Patient Safety (SOPS) Hospital Survey | AHRQ
- Improving Patient Safety in Hospitals: A Resource List for Users of the AHRQ Hospital Survey on Patient Safety Culture | AHRQ
- Spreading Bundle Tools and Resources on High Reliability Culture | CMS Quality Improvement Organizations
- HQIC Monthly Reports
- HQIC Supplemental Leadership Report
- High Reliability Practices for Daily Huddles | HQIN
- Five Whys Worksheet | HQIN

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Resources Continued

- Huddle Quick Start Guide | HQIN
- High Reliability Leadership Learning Module Series: Module #2 | YouTube | HQIN
- High Reliability Leadership Learning Module Series: Module #3 | YouTube | HQIN
- RCA2: Improving Root Cause Analyses and Actions to Prevent Harm | IHI
- Find Healthcare Providers Near You | Medicare

Domain 4: Accountability and Transparency

Accountability for outcomes, as well as transparency around safety events and performance, represents the cornerstones of a culture of safety. For hospital leaders, clinical and non-clinical staff, patients, and families to learn from safety events and prevent harm, there must exist a culture that promotes event reporting without fear or hesitation, and safety data collection and analysis with the free flow of information.

Attestation Statements

A. Our hospital has a confidential safety reporting system that allows staff to report patient safety events, near misses, precursor events, unsafe conditions and other concerns, and prompts a feedback loop to those who report.
B. Our hospital reports serious safety events, near misses and precursor events to a Patient Safety Organization (PSO) listed by AHRQ that participates in voluntary reporting to AHRQ's Network of Patient Safety Databases.
C. Patient safety metrics are tracked and reported on to all clinical and non-clinical staff and made public in hospital units (e.g., displayed on units so that staff, patients, families, and visitors can see).
D. Our hospital has a defined, evidence-based communications and resolutions program reliably implemented after harm events, such as AHRQ's Communication and Optimal Resolution (CANDOR) toolkit, that contains the following elements:
    1. Harm event identification
    2. Open and ongoing communication with patients and families about the harm event
    3. Event investigation, prevention, and learning
    4. Care-for-the-caregiver
    5. Financial and non-financial reconciliation
    6. Patient-family engagement and on-going support
E. Our hospital uses standard measure to track the performance of our communication and resolution program, and reports these measures to the governing board at least quarterly.

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Resources

- Patient Safety Organizations | AHRQ
- Communication and Optimal Resolution (CANDOR) | AHRQ
- Introduction to Communication and Optimal Resolution (CANDOR): Video | AHRQ
- Visual Management Board Component Kit | AHRQ
- The Michigan Model: Medical Malpractice and Patient Safety at Michigan Medicine | University of Michigan Health

Domain 5: Patient and Family Engagement

The effective and equitable engagement of patients, families, and caregivers is essential to safer, better care. Hospitals must embed patients, families, and caregivers as co-producers of safety and health through meaningful involvement in safety activities, quality improvement, and oversight.

Attestation Statements

A. Our hospital has a Patient and Family Advisory Council (PFAC) that ensures patient, family, caregiver, and community input to safety-related activities, including representation at board meetings, consultation on safety goal-setting and metrics, and participation in safety improvement initiatives.
B. Our hospital's PFAC includes patients and caregivers of patients who are diverse and representative of the patient population.
C. Patients have comprehensive access to and are encouraged to view their own medical records and clinician notes via patient portals and other options, and the hospital provides support to help patients interpret information that is culturally-and linguistically-appropriate as well as submit comments for potential correction to their record.
D. Our hospital incorporates patient and caregiver input about patient safety events or issues (such as patient submission of safety events, safety signals from patient complaints or other patient experience data, or patient reports of discrimination).
E. Our hospital supports the presence of family and other designated persons (as defined by the patient) as essential members of a safe care team, and encourages engagement in activities such as bedside rounding and shift reporting, discharge planning, and visitation 24 hours a day, as feasible.

Resources

- Patient and Family Advisory Councils: Resources for the Field | AHA
- Culturally and Linguistically Appropriate Services (CLAS) Action Plan | HQIN
- Simple Strategies for Establishing a Patient and Family Advisory Council (PFAC) | HQIN
- Advancing Effective Communication: A Road Map for Hospitals | The Joint Commission

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