Hospital Focus

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Board Guidance on the New Patient Safety Structural Measures

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In the 25 years since *To Err Is Human* was published, the federal government has taken many steps to promote improvements in the quality and safety of care in United States hospitals. These include foundational safety standards contained within the Centers for Medicare and Medicaid Services' (CMS) Conditions of Participation, various payment adjustment programs (e.g., incentive/risk programs) to improve quality, and periodic grant programs to drive reductions in patient harm (e.g., Hospital Engagement Networks). This article orients hospital board members to the Patient Safety Structural Measure (PSSM), which is a new CMS regulation that became effective on October 1, 2024. The PSSM is designed and promises to strengthen hospitals' tangible commitment to safety and to drive and accelerate our efforts to progressively eliminate preventable harm.

What Is the Patient Safety Structural Measure?

The PSSM is an attestation-based measure included in the 2025 CMS Final Rule for the Hospital Inpatient Prospective Payment System (PPS). Hospitals subject to the Hospital Inpatient Quality Reporting (IQR) Program as well as the PPS-Exempt Cancer Hospital Quality Reporting Program will be required to report on their adherence to 25 recommendations for enhanced safety governance, culture, structure, and processes. The 25 recommendations are grouped into five domains of five attestation statements, and applicable hospitals must report annually on whether they meet each of the five statements within each domain (i.e., for a maximum of five points). This is similar to

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harm prevention bundles board members may be familiar with from their safety reporting on efforts to prevent types of harm like central line-associated bloodstream infections (CLABSIs) where we measure our reliability with bundle adherence as an "all or none" measure. If we successfully complete only four of five required prevention steps, that is scored as non-compliant with the bundle.

So it is with the PSSM. Below is a summary of the five domains, each with several general expectations and some specific requirements. In spring 2026, hospitals will begin attesting as to their full adherence to each of the five bundles. They will earn one point for each of the five domains where they are adherent to all included elements.[1]

1. Leadership Commitment to Preventing Harm

This domain includes general statements most hospitals should easily be able to attest to, including the governing board prioritizing safety, hospital executives overseeing safety assessments, and ongoing safety improvement as well as ensuring there are adequate resources to support patient safety. More specifically, however, hospitals will be asked to attest to two practices that may not currently be in place:

- First, hospitals will need to attest that they are spending 20 percent of their governing board's meeting agenda time discussing issues related to patient and workforce safety (e.g., safety outcomes, improvement work, risk assessments, event cause analysis, etc.).
- Second, hospitals will need to attest that the "executive team and individuals on the governing board are notified within three business days of any confirmed serious safety events (SSEs) resulting in significant morbidity, mortality, or other harm."

Key points:

1. Only time at the governing board is relevant, not time at a quality or safety committee.
2. In addition to standing agenda time for safety topics, boards are encouraged to include safety considerations in other agenda topics and can count that time towards meeting this measure. Time spent on safety considerations during other board discussions (e.g., potential risks and mitigation strategies for new programs or facilities being contemplated) would count towards the 20 percent requirement.
3. There is variability in the definition hospitals use for SSEs and how "significant morbidity, mortality, or other harm" is interpreted. Importantly, the technical language in the measure's background materials does *not* specify that the SSE definition be grounded in an error or deviation that causes harm as it is in many hospitals' tracking of SSEs.

1 Links to the full language for each of the 25 measures as well as resources to assist hospitals in understanding the measures and their definitions appear at the end of this article.

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4. Hospitals may determine which events they will include in their SSE reporting policy and process for notification of executive team and board members after safety events. The timeframe for this requirement can and should be interpreted as three days from when the event is *confirmed* to be a serious safety event, not necessarily within three days of the event itself.

2. Strategic Planning and Organizational Policy

General statements in this domain include the requirement that hospitals have a strategic plan for safety that demonstrates its "commitment to patient safety as a core value," with specific safety goals and measures, including a focus on equity and health disparities in safety results. There is an expectation that the hospital has written policies to promote fair and just culture, as well as a plan for workforce safety, also with metrics to address common risks to hospital staff (e.g., slips, trips, and falls; violence prevention; safe patient handling, etc.).

Specific requirements that hospitals may not have in place include:

- The hospital safety plan should include a goal of "zero preventable harm."
- The hospital "requires implementation of a 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."

Key points:

1. People debate on the pros and cons of "zero preventable harm goals." I have been squarely in the camp of those believing that there is no other appropriate target than zero for the amount of preventable harm we should tolerate in our systems. "Target: just a small amount of harm" is certainly not acceptable. There is growing recognition, however, that our focus in advancing safety in healthcare today may be directed more appropriately towards building capacity and resilient systems as opposed to simply looking backward and trying to learn from the occurrence of serious events of harm. Perhaps the most appropriate response to the ongoing discussions will be to state our having an aspirational goal of progressively eliminating preventable harm while also acknowledging the need for interval improvements in our systems and increasing our focus on reliable and resilient system design.
2. The second metric will be a significant change for many organizations for whom training, competencies, and regular assessments related to safety for *all* staff as well as individuals on the governing board are not part of current practice. Meeting this

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new requirement will be an opportunity to invest in capacity building for both patient and workforce safety.

Note: to get credit for any of the five domains, the hospital must attest to *all* of the included statements within the domain.

3. Culture of Safety and Learning Health Systems

This domain requires a hospital-wide culture of safety assessment annually, or every two years if pulse surveys are conducted on defined units on the off years. CMS specifies that results must be shared with staff and with the board. Most hospitals will meet the requirement of having a team that conducts event analysis with an evidence-based approach after SSEs, and a patient safety metric dashboard with external benchmarks. Similarly, most hospitals should be able to meet a requirement of having implemented at least four of a set of "high-reliability practices." These include:

- Some version of unit and organizational daily safety briefs (including at least one weekend day)
- A monthly leadership safety walk rounds program (at least quarterly for C-suite members), with a method for follow up of issues
- A data infrastructure to measure safety and track serious and precursor safety events
- Computerized physician order entry and bar code scanning for medication administration
- Use of a defined improvement method (e.g., Lean, model for improvement/PDSA, etc.)
- Team communication and collaboration training for all staff
- Use of human factors engineering principles in device, equipment, and process selection

The last requirement in this domain is that the hospital participates in a "large-scale learning network" for patient safety improvement, shares data and outcomes with the network, and has implemented one or more best practices.

Key points:

1. There may be some subjectivity as to what counts as a "large-scale learning network for improvement." The measure language refers to national and state safety collaboratives and the attestation guide provides two examples (Children's Hospitals' Solutions for Patient Safety and Partnership for Patients' networks). Note that

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membership in a patient safety organization may not meet this requirement per se (see domain four below).

2. Several existing as well as new organizations will likely develop, promote, and make available participation in various learning health safety improvement networks to assist hospitals with meeting this new PSSM requirement. Board members should ask their executive teams whether they are currently participating in a learning safety network and, if not, whether there are plans to do so.
3. Many learning health networks have proven to be highly effective and demonstrated sustained improvements in both clinical quality and patient safety, so this is a promising enabling strategy.

4. Accountability and Transparency

To meet this domain, hospitals will have to attest that they have a confidential safety reporting system, that they participate in an AHRQ-listed Patient Safety Organization, and that they track and broadly report patient safety metrics. Specific potential challenging elements in this domain include:

- Patient safety metrics must be reported to all clinical and non-clinical staff and made public in hospital units for all to see, including patients, families, and visitors.
- The measure requires that hospitals have a "defined, evidence-based communication and resolution program that is implemented reliably after harm events." The Communication and Optimal Resolution (CANDOR) toolkit from AHRQ[2] is mentioned as an example, but the program must include harm event identification, open and ongoing communication with patients and families, event review and learning, care for the caregiver, financial and non-monetary compensation, and ongoing support. This program must be tracked as to its performance with reporting to the hospital governing board quarterly.

Key points:

1. This measure may be the one requiring the most change for many hospitals.
2. CANDOR-type programs have demonstrated encouraging results, and many have helped reduce malpractice costs, but they are not universal and different states may have different regulations.
3. Legal and risk management teams and governing boards in hospitals not yet using these programs should avail themselves of the many resources available (see sidebar with resource links).
4. There are patients and family members who have been harmed in our healthcare systems and then also experienced the additional harm of inadequate disclosure and/or lengthy malpractice processes. Some of them have contributed to the

2 See www.ahrq.gov/patient-safety/settings/hospital/candor/index.html.

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development of these new measures. We in health system leadership have an obligation to improve our approach to disclosure, and an opportunity to transcend our long history of traditional "deny/defend" approaches in our malpractice system.

5. Patient and Family Engagement

The requirements in this domain are that hospitals have a Patient/Family Advisory Council, and that the council has a representative and diverse membership that reflects the population served. Patients must have access to their own medical records and clinician notes, and patients/families can provide input on safety events/issues and experience to the hospital (including reports of discrimination). Finally, family members and other designated people are included as essential members of the healthcare team and can participate in bedside rounding, shift reporting, and have 24-hour visitation if feasible.

Board members are encouraged to probe in their questions about these critically important elements, some of which are federal requirements (e.g., record access, grievance reporting). These factors have all been the norm in children's hospitals for many years, but the inclusion of family members as part of the care team seems to be less consistent in the care of adult patients, including elderly and other patient populations where cognition may be compromised. While admittedly anecdotal, my experience with my 92-year-old father's care this past year in two well-respected hospitals has made very clear the opportunities in this regard.

Conclusion

Reporting/attestation of hospital adherence to these five PSSM domains will begin in April 2026 and cover the 2025 reporting period that started January 1, 2025. There is no current monetary incentive or penalty associated with the score hospitals report; however, hospitals that fail to report will be penalized financially starting in fiscal year 2027 (beginning October 1, 2026). CMS will publicly report each hospital's total score (zero to five) on its Hospital Compare site starting in late 2026 but does not expect to report at a finer level of granularity. Hospitals can use tools in the public domain to do a gap analysis, as well as to assist them with meeting the requirements of the PSSM (see link to the Safer Together Self-Assessment tool below). Note that the PSSM reporting requirement applies only to hospitals in the inpatient prospective payment system, so children's hospitals, long-term care facilities, inpatient psychiatric hospitals, and rehabilitation hospitals are currently excluded. These facilities might still consider completing a gap analysis not only in anticipation of the PSSM requirements potentially being extended in the future, but also for the enabling strategies they may offer to strengthen their own organizational safety. Finally, while meeting all five of these rule bundles will initially be

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difficult for many hospitals, getting started and working continuously and systematically are the key ingredients to achieving our objectives in any improvement effort. Board members have an important role to play in ensuring attention to these structural measures and encouraging ongoing improvement.

Resources

A link to the full verbiage for each structural measure and its five components can be found here: https://hqin.org/wp-content/uploads/2024/07/Quick-Start-Guide-Patient-Safety-Structural-Measure.pdf

Attestation guide (with measure clarifications)
https://qualitynet.cms.gov/files/66ac08646a3d89e3e32733c4?filename=PSSM_AttestationGuide_073124.pdf

PSSM Specifications
https://qualitynet.cms.gov/files/66ac085486c07e0c5ec5e930?filename=PSSM_Specs_073124.pdf

Reporting specifics
https://qualitynet.cms.gov/inpatient/iqr/measures#tab2 (inpatient)
https://qualitynet.cms.gov/pch/measures (PPS exempt cancer hospitals)

National Action Plan to Advance Safety and the Safer Together Self-Assessment tool from the Institute for Healthcare Improvement:
https://www.ihi.org/national-action-plan-advance-patient-safety

TGI thanks Daniel Hyman, M.D., M.M.M., Chief Safety and Quality Officer, Children's Hospital of Philadelphia, for contributing this article. He can be reached at danhyman2@gmail.com.

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