

Building a Culture of Safety Utilizing the Patient Safety Structural Measure (PSSM) Domain Series: Accountability and Transparency

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July 2, 2025



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Housekeeping

- Who's in the room today? (Name, organization, role)
- To eliminate any background noise during today's presentation your audio has been muted upon entry.
- We encourage questions and open discussion through the Chat box, or you can raise your hand to be unmuted and engage verbally.
- This event is being recorded.

Introducing

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Objectives

1. Examine the principles of accountability in patient safety.
2. Discuss the importance of transparency in safety reporting and communication.
3. Identify tools and metrics for measuring and reporting safety performance.

Review

- PSSM Overview
- PSSM Leadership Domain
- PSSM Strategic Planning & Organizational Policy
- PSSM Culture of Safety and Learning Systems

Overview of PSSM

The Patient Safety Structural Measure (PSSM)

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

NATIONAL
ACTION
ALLIANCE
for Patient and
Workforce Safety

 Leadership Commitment to Eliminating Preventable Harm	 Strategic Planning and Organizational Policy	 Culture of Safety and Learning Systems	 Accountability & Transparency	 Patient & Family Engagement
Our hospital leaders, including C-suite executives, place patient safety as a core institutional value. Plans and metrics are widely shared. across the hospital and governing board” ✓ C-suite oversees safety self-assessment Governing board ensures adequate resources to support patient safety Notification of serious safety events to C-suite executives and BoD members within 3 business days	Commitment to “zero preventable harm” Hospital requires implementation of patient safety competencies for all Hospital has action plan for workforce safety Written just culture policy to that balances no blame and appropriate accountability	Hospital conducts hospital-wide culture of safety survey Our hospital implements at least 4 High Reliability Organization Practices ✓ Hospital implements team communication training Hospital participates in large-scale learning network(s) for patient safety	Hospital works with PSO listed by AHRQ to carry out patient safety activities Hospital has a Communication and Resolution Program (CRP), such as AHRQ’s CANDOR toolkit Hospital measures CRP program performance	Hospital has Patient and Family Advisory Council (PFAC) that provides input on safety-related activities Patients have comprehensive access to medical records via patient portals. Hospital provides support and allows patients to submit comments for potential correction to their record Hospital supports the presence of family (as defined by the patient) as members of the care team

Which Hospitals are Covered by the Final Rule?



- All acute care hospitals participating in the Hospital Inpatient Quality Reporting (IQR) and PPS Exempt Cancer Hospital Quality Reporting (PCHQR) programs face a reduction in their Annual Percentage Update if they fail to report on the measure.
- The rule does not apply to certain acute hospitals outside of the IQR and PCHQR programs, such as psychiatric hospitals, rehabilitation facilities, children's hospitals, and critical access hospitals.

Additional Q&A

- How will the Patient Safety Structural Measure be carried out?
 - Each year, hospitals will be asked to attest to a series of statements related to each of the five domains. The statements are designed to assess the degree to which each hospital has implemented the most salient strategies and practices for strengthening safety culture and systems within each domain.
- When will hospital reporting on the Patient Safety Structural Measure begin?
 - Annual hospital reporting on the measure started in CMS's reporting period for Calendar Year 2025. The pay-for-reporting incentive for that first year will be reflected in IQR hospitals' FY 2027 payment determinations. Hospitals that do not report will face a reduction in their annual Medicare payment.
- Will the information be public?
 - Yes. Beginning in the fall of 2026, CMS will publish each hospital's Patient Safety Structural Measure score on Care Compare on Medicare.gov. Hospitals will report a score of 0-5, with one point for each domain in which the hospital has attested in the affirmative to every statement.

Polling Question 1

- Why are you joining today
 - Actively working on this measure and want to learn more
 - Not actively working on this measure but want to make improvements in our Culture of Safety and Patient Safety Program
 - Want to learn all I can now to start working on as may be a requirement in future
 - Not working on but I want to learn more about Patient Safety

Accountability and Transparency

Domain 4 Overview



- High-reliability practices are essential for maintaining a safe environment for both patients and staff. These practices include daily safety huddles and monthly rounding for safety.
- During the measure vetting process, patients and patient advocates were very supportive of this domain. They supported the opportunity to join these discussions, learn about the process and have hospitals openly address these issues.

Accountability and Transparency Domain 4

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.

Accountability and Transparency Domain 4 (cont'd)

- 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.
- 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.

Accountability and Transparency Domain 4 (cont'd)

- 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).
- 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
- Our hospital uses standard measures to track the performance of our communication and resolution program, and reports these measures to the governing board at least quarterly

Accountability and Transparency- Element 1



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

Accountability and Transparency- Element 1 Group Discussion



Polling Question Element 1

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

- Yes
- No
- Unknown

Accountability and Transparency-

Element 2



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.

Accountability and Transparency- Element 2 Group Discussion



Polling Question Element 2

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.

- Yes
- No
- Unknown

Accountability and Transparency-

Element 3



- 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)

Accountability and Transparency- Element 3 Group Discussion



Polling Question Element 3

Our hospital tracks patient safety metrics and those metrics are displayed in public areas of the hospital for everyone to see

- Yes
- No
- Unknown

Accountability and Transparency-Element 4

- 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:
 - Harm event identification
 - Open and ongoing communication with patients and families about the harm event
 - Event investigation, prevention, and learning
 - Care-for-the-caregiver
 - Financial and non-financial reconciliation
 - Patient-family engagement and on-going support

Accountability and Transparency- Element 4 Group Discussion



Polling Question Element 4

Our hospital has a process in which staff have a communication and resolution program to follow when a harm event occurs.

- Yes
- No
- Unknown

Accountability and Transparency-

Element 5



- Our hospital uses standard measures to track the performance of our communication and resolution program, and reports these measures to the governing board at least quarterly
 - “Standard measures” may include number of resolutions achieved, amount of time for resolution to occur, and total compensation paid to patients when inappropriate medical care causes harm.

Accountability and Transparency- Element 5 Group Discussion



Polling Question Element 5

Our hospital uses standard measures to track the performance of the communication and resolution program, and this is reported to the board on a quarterly basis

- Yes
- Yes, but not quarterly
- No
- Unknown

Conclusion

Call to Action:

- Evaluate and improve incident reporting process
- Start reporting serious safety events, near misses and precursor event
- Share safety metrics with staff and patients
- Implement an evidence-based communications and resolutions program and begin reporting

Resource Links

- [HQIN - Quick Start Guide: Patient Safety Structural Measure](#)
- [CMS - Hospital Inpatient Quality Reporting \(IQR\) Program Measures](#)
- [IHI - New CMS Measure Aims to Advance Safety](#)
- [AHA - The Board's Role in Quality and Patient Safety](#)
- [IHI - Transforming Safety with the CMS PSSM & National Action Plan Webinar](#)
- [IHI - Leadership Guide to Patient Safety](#) (includes a self-assessment tool)

Resources for Element 1

- [AHRQ - The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents](#)
- [AHRQ - About the CUSP Method](#)
- [AHRQ - TeamSTEPPS 3.0](#)
- [AHA - Workforce and Workplace Violence Prevention](#)
- [AONL - ENA Workplace Guiding Principles](#)
- [HQIN - Health Equity Action Plan](#)

Resources for Element 2

- [IHI - Patient Safety Taxonomy](#)
- [CDC - Healthy Work Design and Well-Being Program](#)
- [CDC - Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings](#)
- [ASHP - Just Culture Toolkit](#)
- [AHRQ - Healthcare Safety Competencies Affinity Group](#)

Resources for Element 3

- [AHRQ - SOPS Hospital Survey](#)
- [AHRQ - Improving Patient Safety in Hospitals: A Resource List for Users of the AHRQ Hospital Survey on Patient Safety Culture](#)
- [HQIN - Five Whys Worksheet](#)
- [HQIN - High Reliability Practices for Daily Huddles](#)
- [IHI - Improving Root Cause Analyses and Actions to Prevent Harm](#)
- [IHI - Huddle Quick Start Guide](#)

Resources for Element 4

- [AHRQ - CANDOR](#)
- [AHRQ - Patient Safety Organization \(PSO\)](#)
- [AHRQ - Introduction to Communication and Optimal Resolution \(CANDOR\)](#)
- [AHRQ - Visual Management Board Component Kit](#)
- [The Michigan Model - Medical Malpractice and Patient Safety at Michigan Medicine](#)

Resource Element 5

- [The Joint Commission - Board Education on Quality and Patient Safety](#)
- [Healthcare Executive - Engaging the Board in Patient Safety](#)
- [AHA - Board Role in Quality and Patient Safety](#)
- [AHA - Roadmap towards Effective Governance for Quality and Patient Safety](#)

Questions?



Upcoming Events

- **Next Compass Learning and Action Network Series: *Building a Culture of Safety Series- Culture of Safety & Learning Health Safety***

August 6, 2025, from 1:00-1:50 PM CST

Topic: Patient and Family Engagement

[Registration](#)

- **Compass Sharing Progress, Amplifying Resources and Knowledge (SPARK) Call**

July 16, 2025, from 1:00-1:30 PM CST

[Registration](#)

- **Compass Patient Safety Conference**

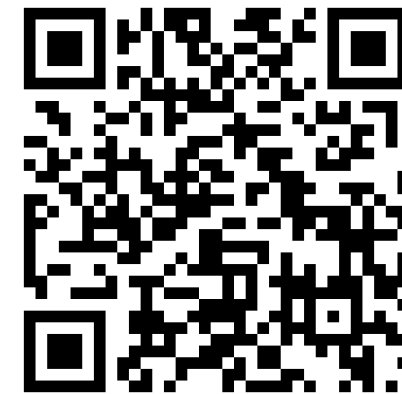
September 9-10, 2025, at the Meadows Events & Conference Center in Altoona Iowa

[Details](#)

iCompass Academy



- This webinar will be recorded and will be available on iCompass Academy
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 - iCompass Academy offers an online suite of free eLearning products, including webinars, courses, and virtual events that can be accessed anywhere at any time.

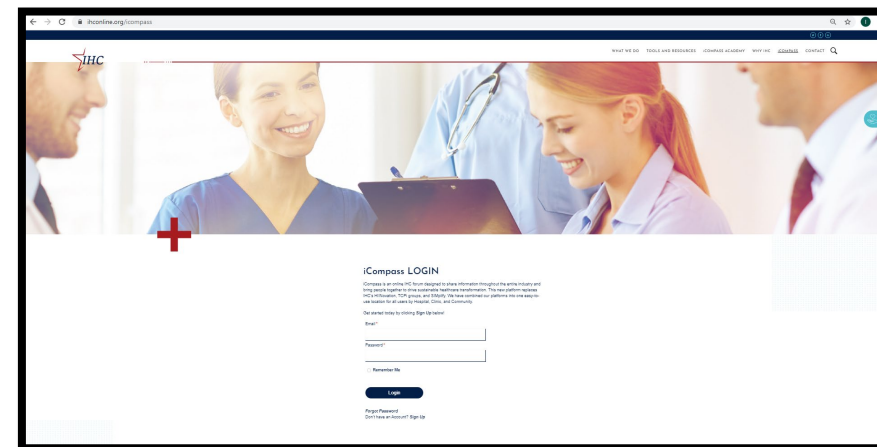


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iCompass



- We encourage you all to also join us on our communication platform, iCompass.
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Thank you!

- Please reach out to Compass staff if you have any additional questions or need assistance



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