ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

AHA Data & Insights

ASHRM Toolkit

Patient Safety Structural Measure (PSSM)

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Section 1: Purpose of This Toolkit

This toolkit is designed to help health care risk, quality and patient safety professionals understand *why* the CMS Patient Safety Structural Measure (PSSM) exists, *what* it is intended to assess, and *how* organizations can operationalize it in a meaningful way.

Why this measure exists: CMS has identified a need to reignite and reinforce the importance of safety culture across health care organizations. Existing CMS patient safety measures have historically emphasized outcomes, with less focus on the underlying *structures, culture, and leadership commitment* required to sustain safe care. The PSSM was developed as a mandatory attestation measure to fill this gap and to signal that patient safety must be intentionally led, governed, and supported at the organizational level.

How the measure works: By evaluating foundational elements—organizational structure, safety culture, and leadership commitment—the PSSM allows CMS and organizations themselves to assess whether a hospital has the conditions in place to prioritize safety consistently. Strengthening these foundational components can, in turn, reinvigorate and improve all elements of patient safety performance, including the organization's safety culture.

What the measure is assessing: The PSSM is anchored in evidence-based best practices shown to improve patient safety and reduce harm. It uses a total systems framework that views patient safety events as the result of system failures rather than individual error. The measure is structured to assess both *processes* and *outcomes* related to patient safety and is aligned with the IHI / National Safety Council *Safer Together: A National Action Plan to Advance Patient Safety*.[1]

This toolkit translates that intent into practical actions, governance structures, and documentation approaches that can be embedded into existing enterprise risk management (ERM), patient safety, and quality frameworks, rather than serving as a one-time compliance exercise.

[1] Institute for Healthcare Improvement. Safer Together: A National Action Plan to Advance Patient Safety. Accessed 20 February 2026. https://www.ihi.org/national-action-plan-advance-patient-safety

What This Toolkit *Is*

- A **practical implementation guide** for the CMS Patient Safety Structural Measure
- A **bridge between regulation and operations**, aligning CMS expectations with day-to-day risk, quality, and safety work
- A **reference and working resource** that can be revisited as governance, leadership, or regulatory expectations evolve

What This Toolkit *Is Not*

- It is **not a legal or regulatory interpretation** or a substitute for formal CMS guidance
- It is **not a prescriptive checklist** that guarantees compliance without thoughtful application
- It is **not limited to one department**; successful use requires cross-functional engagement
- It is **not a standalone patient safety program**, but a structural overlay that supports existing programs

Intended Users

This toolkit is designed for multidisciplinary use, with primary audiences including:

- **Enterprise Risk Managers** responsible for governance, oversight, and regulatory readiness
- **Patient Safety Leaders** overseeing reporting systems, learning processes, and improvement efforts
- **Quality and Performance Improvement Leaders** aligning safety structure with outcomes
- **Clinical Leaders and Service Line Directors** accountable for operational execution
- **Executive Sponsors and Board Liaisons** responsible for leadership accountability and oversight

Secondary users may include compliance professionals, accreditation leads, legal/risk counsel, and data analytics teams supporting safety infrastructure.

Uses of this Toolkit

Regulatory and External Drivers

- Introduction or clarification of the CMS Patient Safety Structural Measure
- Attestation readiness
- Requests for evidence of patient safety governance or leadership accountability

How to Use This Toolkit

Users should approach this toolkit as a **guided pathway**, not a linear checklist. Sections can be used independently based on organizational needs, but together they provide a comprehensive framework for meeting CMS structural expectations. Risk, quality and safety professionals are encouraged to:

- Assess the current state before implementing new structures
- Engage appropriate stakeholders early
- Document rationale and decisions, not just activities
- Revisit and refine structures as the organization and regulatory environment evolve

Used thoughtfully, this toolkit can support not only CMS compliance but also stronger, more resilient patient safety governance across the organization.

Who the PSSM Applies To and How It Is Scored

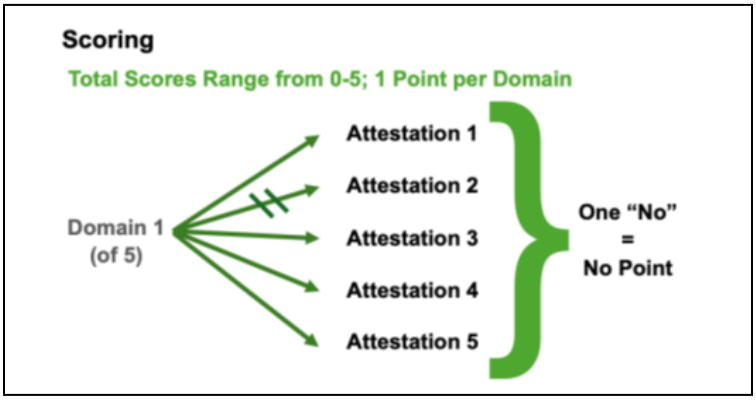
Applicability: The CMS Patient Safety Structural Measure (PSSM) is a mandatory reporting measure for acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) and the Prospective Payment System, with an exemption for cancer hospitals. The measure does not apply to statutorily exempt facilities, including children's hospitals, inpatient psychiatric hospitals, long-term care hospitals, and inpatient rehabilitation facilities. Critical Access Hospitals are not required to report but may do so voluntarily.

Scoring Methodology: The PSSM uses an all-or-nothing scoring methodology across five domains, for a total of five possible points (one point per domain). To

receive credit for a domain, a hospital must affirmatively attest to *every* required statement within that domain.

- There is **no partial credit** within a domain.
- A single "No" response to any attestation statement results in **zero points for the entire domain**.
- Failure to submit an attestation results in an **automatic zero** and may trigger a **financial penalty**.
- If a group of hospitals is under **one CCN #,** aka the Medicare Provider number, **all hospitals must meet all 5 domains & attestations to score positively.**

This all-or-nothing approach underscores CMS's intent: patient safety infrastructure must be comprehensive and consistently applied, not selectively implemented.



CCN Score: The PSSM facility score is assigned at the CCN (CMS Certification Number) level based on the hospital(s) reporting under that CCN. For the single-facility CCNs, the Facility Score is the CCN score. For multi-facility CCNs, the lowest facility score of the participating hospitals with the shared CCN is the CCN Score. CCN scores are sent to CMS on behalf of the participating hospitals for use in the IQR and PCHQR programs and public reporting following the annual May 15th CMS deadline for PSSM.

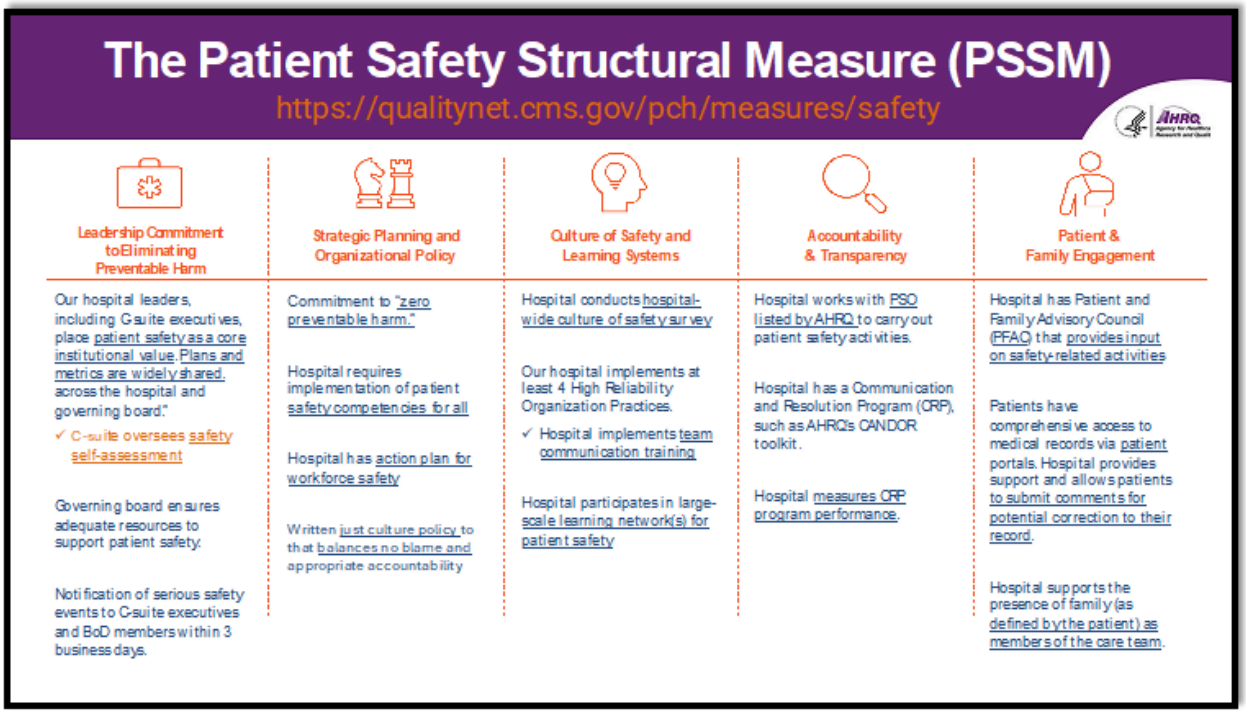
Example 1: Hospital A has a single-facility CCN. Hospital A's facility score is five (5); therefore, Hospital A's CCN score is also five (5). Example 2: Hospital B shares CCN 111111 with Hospital C. Hospital Bs facility score is four (4). Hospital C's facility score is two (2). The CCN score for CCN 11111 is two (2), which is the lowest facility score for the hospitals that share this CCN.

Why the Score Matters: Beyond payment implications, PSSM performance carries reputational significance. A hospital's ability to demonstrate strong patient safety structure and leadership commitment may influence public perception through external rating and comparison platforms such as Hospital Compare, Leapfrog Group scores, U.S. News & World Report rankings, and Newsweek's *Best Hospitals* lists. Hospitals and health systems should consider not only *how* they will score on the PSSM, but *what that score signals* to patients, staff, regulators, and governing bodies about their commitment to patient safety.

Reporting Period and Public Reporting Timeline

The first PSSM reporting period runs from January 1, 2025, through December 31, 2025**.** Hospitals will attest annually to performance during the *prior calendar year*, with attestation submitted each spring—anticipated around April—through the NHSN application**.** For the year 2025, the reporting period will be April 1 to May 15, 2026. CMS plans to publicly report hospital PSSM scores on **Hospital Compare**, with initial public reporting expected in **October 2026**. Hospitals should note that **failure to submit an attestation results in an automatic zero score and may trigger a financial penalty**, underscoring the importance of timely and accurate reporting.

Section 2: Tools



The PSSM Five Domains

The PSSM consists of 5 domains:

- **Domain 1** - Leadership commitment to eliminating preventable harm.
- **Domain 2** - Strategic planning and organizational policy.
- **Domain 3** - Culture of safety and learning.
- **Domain 4** - Accountability and transparency.
- **Domain 5** - Patient and family engagement.

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Domain 1:
Leadership Commitment to Eliminating Preventable Harm

Attestations

1A. 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 & compensation**.
1B. 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. (You can use the IHI self-assessment tool that is included in section 5: Resources.) Also, in 1B that the execution of patient safety initiatives and operations, with specific improvement plans and metrics. **These plans and metrics are shared across the hospital & governing board.**
1C. Our hospital governing board, in collaboration with leadership, **ensures adequate resources to support patient safety** (such as equipment, training, systems, personnel, and technology).
1D. Reporting on patient 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 regular board agenda & discussion time for senior GB meetings.**
1E. C-suite executives and individuals on the governing board are notified within 3 business days of any **confirmed** serious safety event resulting in significant morbidity, mortality, or other harm. (**Confirmed is the key word.)**

Domain 1, Continued

Public Comments: Peer Perspectives

- **1A: Clarification on Performance Review Requirements.**

A commenter asked whether Domain 1A required leadership performance reviews to cite specific patient safety metrics or simply demonstrate the implementation of safety and quality initiatives. CMS clarified that they intentionally did **not** require specific metrics. Instead they allow hospitals flexibility to adopt performance review practices that best align with their individual circumstances. **This is consistent with the Leapfrog group's annual hospital survey, which similarly integrates senior leader performance review and support for patient safety in its questions.**

- **Domain 1D: Rationale for the 20% Board-Meeting Threshold.**

Commenters raised concerns about requiring at least 20% of all leadership and governing board meetings to focus on patient safety. CMS explained that this threshold is grounded in the *Safer Together: A National Action Plan to Advance Patient Safety*. They emphasized the importance of transparency, trust-building, accountability, and maintaining strong relationships with stakeholders. CMS also acknowledged that public or government-owned hospitals must hold open board meetings, and certain safety discussions involving identifiable or protected information may appropriately occur in closed sessions. Although many governing boards have patient safety subcommittees, CMS reiterated that ultimate responsibility rests with the senior governing board — the body with fiduciary oversight.

- **Domain 1E: Three-Day Notification Timeline for Serious Safety Events.**

Public commenters expressed concern that the requirement to notify senior leadership and the governing board within three business days of a *confirmed* serious safety event (SSE) was too short, given the complexity of analyzing events and forming recommendations. CMS responded that the timeline is drawn from the *Safer Together National Action Plan* and its self-assessment tool, which actually requires notifying the CEO and board chair within **24 hours**. To provide hospitals with greater flexibility, CMS extended this to three business days. CMS also highlighted the importance of the term **"confirmed"** in the attestation, indicating that the clock begins only after an event has been verified as an SSE.

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Domain 1, Continued

Opportunities for Risk Professionals: Next Steps

1. **Volunteer to review performance evaluations**
   - ☐ Consider volunteering to review the annual leadership performance evaluations to ensure patient safety metrics are consistently and meaningfully incorporated.
2. **Leverage your risk expertise to inform the board**
   - ☐ Even if your role is focused strictly on risk management, the data you oversee can meaningfully inform governance. Review the examples listed of what the 20% of GB meetings should consist of: **i.e., improvement work, risk assessments, event cause analysis, or other patient safety topics.**
3. **Ensure timely leadership and board notification of SSEs**
   - ☐ If you manage the event reporting system, you will be integral in assuring hospital leadership & board are notified within **three business days of an SSE.**
4. **Configure automated alerts for potential SSEs**
   - ☐ Confirm your event reporting system is programmed to send automatic notifications when a report may represent an SSE. This allows for timely triage and analysis, especially if an event occurs on a weekend or outside business hours.
5. **Educate clinical leaders on SSE criteria and timely reporting**
   - ☐ Make sure clinical leaders are trained on the definition of SSEs, the criteria used to identify them, and expectations for prompt reporting.
6. **Define board notification processes and content**
   - ☐ Determine the logistics for notifying board leaders and off-site board members. If email is used, clarify what information will be included, the security requirements, and whether members receive them through organizational email accounts or personal addresses.
7. **Engage in system-wide safety assessments**
   - ☐ Assess your level of involvement in the organization's system-wide safety assessment. Do you help administer the survey? Can you drive specific improvement plans and metrics from the results?

Domain 1, Continued

Opportunities for Risk Professionals: Next Steps, Continued

8. **Help to bridge gaps between stakeholders**
   - ☐ Because different departments and functions often operate separately, reducing the gaps between leadership, safety, risk and other key stakeholders in order to carry out the work and help leaders to make informed and effective decisions.
9. **Make success visible**
   - ☐ Consider creating a PSSM Safety Dashboard for the benefit of leadership. You might include SMART metrics including Leading Indicators and Lagging Indicators in order to show the full scope of potential risks.

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Domain 2:
Strategic Planning and Organizational Strategy

How do hospitals leverage their strategic planning & policies to demonstrate a commitment to safety as a core value?

Attestations

2A. Our hospital has a strategic plan that **publicly** shares its commitment to patient safety as a core value, and outlines safety goals and associated metrics, including the goal of "**zero preventable harm."**
2B. Our hospital's 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 the specific populations served.
2C. Our hospital has 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 & reckless behavior.
2D. Our hospital requires implementation of a patient safety curriculum and competencies for all clinical & **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.
2E. 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.**

Domain 2, Continued

Public Comments: Peer Perspectives

- **Community partnerships and safety disparities.**

A public commenter expressed concern that hospitals cannot address community-level disparities without partnerships with external organizations. CMS agreed and clarified that the "hospital safety goals need to include the use of metrics to identify & address disparities in safety outcomes based on the patient characteristics determined by the hospital to be most important to healthcare outcomes for the populations served." CMS responded with examples from the attestation guide, such as AHRQ Patient safety indicators, which include items such as Death Rate in Low-Mortality Diagnosis Related Groups, Pressure Ulcer Rate, along with several others.

- **Just Culture as part of intentional system design.**

A commenter noted that adopting a Just Culture approach is an intentional system design choice. CMS agreed & addressed in the attestation guide that "a Just Culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control," and that many active errors are predictable interactions between people and the systems in which they work. CMS contrasted JC to a "no blame," stating that JC does not tolerate conscious disregard of clear risks to patients or gross misconduct.

- **2D, Patient safety curriculum clarifications.**

In response to public comments, CMS clarified that the patient safety curriculum requirement applies to *all* hospital-based employees—both clinical and non-clinical—and that hospitals may include additional staff at their discretion. CMS purposely provided flexibility so organizations can tailor their curriculum and competency assessments to local needs.

Domain 2, Continued

Public Comments: Peer Perspectives, Continued

- **2D, Patient safety curriculum clarifications, Continued.**
  The attestation guide lists evidence-based, industry-standard programs as examples, including:
  - CUSP (Comprehensive Unit-based Safety Program)
  - AHRQ's CANDOR Toolkit
  - CDC's Infection Control Assessment & Response tools
  - TeamSTEPPS communication framework
  - IHI RCA resources
  - Shared decision-making tools
  - Central-line infection reduction tools
  - Data analytics applications
  - Performance improvement methodologies such as PDSA
  - Ethical standards
- **2E, Workforce safety action plan.**

CMS provided examples of elements that may be included in a workforce safety action plan, while acknowledging it is not a comprehensive list: slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, fire/electrical safety, and psychological safety." Further, note that CMS includes psychological safety & discusses workforce safety as a precondition to advancing patient safety with a unified, total systems-based approach to eliminate harm to both patients & the workforce.

Opportunities for Risk Professionals: Next Steps

1. **Volunteer to review performance evaluations**
   - ☐ Consider volunteering to review the annual leadership performance evaluations to ensure patient safety metrics are consistently and meaningfully incorporated.
2. **Assess whether the strategic plan reflects safety as a core value**
   - ☐ Determine if your strategic plan needs revision to explicitly position safety as a core organizational value, including clearly defined safety goals, associated metrics, and a commitment to zero preventable harm.

Domain 2, Continued

Opportunities for Risk Professionals: Next Steps, Continued

3. **Volunteer to help identify safety and equity metrics**
   - ☐ Consider volunteering to help identify systemwide safety metrics—not only for the strategic plan but also to assess disparities in safety outcomes. Reflect on how you can deepen your involvement in Just Culture practices and implementation.
4. **Serve as a resource for HR on system vs. individual contributions to error**
   - ☐ Evaluate your role as a consultative resource to HR when determining whether an error stems from systemic conditions, latent failures, or an individual behavioral choice.
   - ☐ Consider using an organizational fairness worksheet in the RCA2 process to determine if an employee's behavior was reckless, risky, or unintentional.
5. **Strengthen your role as a Just Culture facilitator and educator**
   - ☐ Identify opportunities to serve as a facilitator or educator for Just Culture principles across your organization.
6. **Review and update patient safety curriculum & competencies**
   - ☐ Determine whether the patient safety curriculum and competency assessments require updates based on the latest CMS guidance.
7. **Ensure the board has safety competencies**
   - ☐ Assess whether your board members have defined competencies related to patient safety, quality oversight, and safety culture.
8. **Engage in team-based safety programs (CUSP, TeamSTEPPS, etc.)**
   - ☐ If your organization uses team-based safety programs such as CUSP or TeamSTEPPS, clarify your role. Are you the content expert or facilitator? If not, consider volunteering to support or co-lead these initiatives.
9. **Evaluate your involvement in workforce safety efforts**
   - ☐ Reflect on the extent of your involvement in workforce safety planning, solutions, and improvement efforts.

Domain 2, Continued

Opportunities for Risk Professionals: Next Steps, Continued

10. **Integrate workforce safety data into event reporting**
    - ☐ Confirm whether workforce injury and hazard data are integrated into the event reporting system for comprehensive analysis and transparency.
11. **Participate in workforce safety teams**
    - ☐ Determine whether you currently serve on a workforce safety committee—and if not, whether your expertise could add value.
12. **Assess organizational attention to psychological safety**
    - ☐ Evaluate how psychological safety is discussed within your organization and whether it's embedded in leadership practices and team norms.
13. **Verify measurement of psychological safety**
    - ☐ Identify whether your organization captures and reports metrics related to psychological safety (e.g., survey results, culture-of-safety domains, team communication measures).

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Domain 3:
Culture of Safety and Learning Health Systems

Assesses whether your hospital integrates evidence-based practices & protocols in cultivating a learning system within & across the hospital.

Attestations

3A. 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. (CMS provided two examples of validated instruments that hospitals can use to conduct surveys: The AHRQ Survey on Patient Safety & the Safety Attitudes questionnaire & then a description of pulse surveys in the attestation guide.)
3B. 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 (RCA2).
3C. 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 activities on safety events (such as medication errors, surgical/procedural harm, falls, pressure injuries, diagnostic errors, and healthcare associated infections).

Domain 3, Continued

Attestations, Continued

3D. Our hospital implements a **minimum of 4 of the following high-reliability practices: (**the list has 7 to choose from, and the attestation guide offers more details on each of these:) • **Tiered and escalating** (for example, unit, department, facility, system) **safety huddles** at least five days per week, with one day being a weekend, that include key clinical and non-clinical (for example, lab, housekeeping, security) units and leaders, with a method in place follow up of issues identified.

- **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 follow up of issues identified.
- **A data infrastructure** to **measure safety,** based on patient safety evidence (for example, systematic reviews, national guidelines) and data from the electronic health record 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.
- **Technologies,** including computerized physician orders **(CPOE)** and a bar code medication administration system **(BCMA),** that promotes safety and standardization of care using evidence-based practices.
- **The use of a defined improvement method** (or hybrid of proven methods) such as Lean, Six Sigma, or Plan-Do-Study-Act, (PDSA) and or high reliability frameworks. • **Team communication and collaboration** training of all staff (Think of TeamSTEPPS).
- The use of **human factor engineering principles** in selection and design of devices, equipment and processes.

3E. Our hospital participates in a large-scale learning network(s) for patient safety improvement (such as national or state safety improvement collaboratives), shares data on safety events and outcomes with these network(s) and has implemented at least one best practice from the network or collaborative.

Domain 3, Continued

Public Comments: Peer Perspectives

• **Scope of Event Evaluation Under 3B.**

A public commenter asked whether the dedicated teams referenced in Section 3B would also be expected to evaluate events that do not meet the threshold for Serious Safety Events (SSEs). CMS clarified that hospitals are required to attest only to teams conducting analyses of *SSEs* using evidence-based approaches. While evaluation of precursor or near-miss events is not required, CMS noted that doing so is considered an even stronger safety practice.

• **Requirements for High-Reliability Practices Under 3D.**

Commenters expressed concern that hospitals would need to implement *all* seven high-reliability practices listed in Section 3D to meet the requirement. CMS clarified that hospitals only need to select and attest to **four of the seven** practices.

- **Daily Huddles:** Several commenters requested clarification about the purpose and activities of daily huddles. CMS responded by adding detail in the attestation guide, noting that the purpose of huddles is to proactively identify potential risks and engage leadership support. A "tiered and escalating huddle system" includes a series of brief, focused daily conversations that rapidly identify and escalate safety, quality, and operational issues from front-line staff to a targeted group of senior leaders.
- **Leader Rounding:** Commenters also questioned the feasibility of requiring every hospital leader to round in every unit each month. CMS agreed that this would be unrealistic for many organizations and maintained flexibility: leaders must round in every unit, but hospitals may determine which leaders do so. C-suite executives must round at least quarterly. CMS clarified that rounds do not need to focus exclusively on safety; they can incorporate other issues as appropriate.

Domain 3, Continued

Public Comments: Peer Perspectives, Continued

- **Requirements for High-Reliability Practices Under 3D. Continued.**
  - **Human Factors Engineering:** One commenter requested clarification regarding the expectation that hospital staff engage in human factors engineering in device, equipment, and process design (one of the optional 3D practices). CMS responded that hospital staff are *not typically expected* to perform human factors engineering in all contexts. Responsibilities may differ by role—for example, senior leaders may influence device or equipment purchasing decisions, while frontline supervisors may help design or refine operational processes. CMS noted that the same employees are not expected to oversee all related activities.

Opportunities for Risk Professionals: Next Steps

1. **Join the serious safety event (SSE) analysis team**
   - ☐ If you are not already a member, ensure you have a defined role on the dedicated SSE analysis team to contribute your expertise to high-risk event reviews.
2. **Strengthen your role in the culture of safety survey process**
   - ☐ Confirm that you are actively involved in the organization's culture of safety survey—both in interpreting results and shaping the action plans that follow.
3. **Support daily safety briefs**
   - ☐ If patient safety responsibilities reside in another role, consider volunteering to co-lead or cross-cover daily safety briefs to enhance interdisciplinary coordination and visibility.
4. **Volunteer to develop electronic rounding tools and serve as the recorder during monthly executive rounds**
   - ☐ This not only supports operational efficiency but also increases your direct engagement with the C-suite and strengthens follow-up on identified concerns.

Domain 3, Continued

Opportunities for Risk Professionals: Next Steps, Continued

5. **Highlight your human factors and improvement science expertise**
   - ☐ Ensure your executive leaders understand any training you have in human factors engineering. If you are skilled in Lean, Six Sigma, PDSA cycles, or other high-reliability frameworks, make sure that expertise is visible and leveraged across improvement efforts.
6. **Be a leader in the RCA2 process**
   - ☐ Use resources such as organizational fairness worksheets within the RCA2 process to evaluate employee behavior and analyze issues that come up.
7. **Engage in value analysis activities**
   - ☐ Participate in value analysis teams where your perspective is essential for evaluating and selecting equipment, devices, and supplies with a human-factors-informed lens to reduce risk and enhance usability.

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Domain 4:
Accountability and Transparency

Domain 4 supports organizational accountability for outcomes and transparency around safety events and performance.

Attestations

4A. 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.**
4B. Our hospital **voluntarily works with a Patient Safety Organization (PSO)** listed by the Agency for Healthcare Research and Quality (AHRQ) to carry out patient safety activities, as described in 42 CFR 3.20, such as, but not limited to, the collection and analysis of patient safety work product, dissemination of information such as best practices, encouraging a culture of safety, or activities related to the operation of a patient safety evaluation system.
4C. Patient Safety **metrics are tracked** & reported to all clinical and **non-clinical staff and made public in hospital units (for example, displays on units so that staff, patients, families and visitors can see**.
4D. Our hospital has a defined evidence-based communications & resolution program reliably implemented after harm events, such as the AHRQ Communication and Optimal Resolution (CANDOR) toolkit, that contains the following elements: Harm event identification; Open and ongoing communication with the patients and family 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. See section 5 for CMS links to AHRQ's CANDOR toolkit in the federal register and the tool kit here: **Communication and Optimal Resolution (CANDOR) Toolkit**
4E. Our hospital uses standard measures to **track the performance** of the communications & resolution program & **reports these measures to the governing board at least quarterly**. CMS states in the guide "standard measures" may include number of resolutions achieved, amount of time resolution to occur, & total compensation paid to patients when inappropriate medical care causes harm.

Domain 4, Continued

Public Comments: Peer Perspectives

- **Clarification on PSO participation requirements.**

Public commenters expressed concern that participation in a Patient Safety Organization (PSO) would be mandatory and could affect hospital reimbursement based on actions outside the hospital's control. CMS clarified that hospitals may participate in a PSO **without submitting events, near misses, or precursor events**, as long as they are engaged in other patient safety activities with the PSO.

- **Effect on hospital reimbursement**.

CMS confirmed that the only potential impact on hospital reimbursement would occur if a hospital participating in the Hospital IQR Program **chooses not to report the measure at all** and does not submit the measure to NHSN. No additional reimbursement penalties are tied to PSO participation, at this time.

Domain 4, Continued

Public Comments: Peer Perspectives, Continued

• **Use of AHRQ common formats**.

Some commenters raised concerns that the PSSM would require hospitals and PSOs to use AHRQ's Common Formats when reporting to the National Patient Safety Database (NPSD). CMS clarified that:

- The modified **Domain 4, Statement B** no longer references NPSD submission. Hospitals and PSOs have flexibility to use reporting formats that work best for their partnership.

• **Use of AHRQ common formats is voluntary** and available as an optional tool for standardizing event reporting.

- For those unfamiliar with Common Formats, CMS noted that these templates help structure event data to support standardized aggregation. Hospitals may find it valuable to compare the AHRQ templates with their current event-reporting system, as not all vendors fully align with these standards: **https://www.psoppc.org/psoppc_web/publicpages/commonFormatsHV2**
- Using these formats can strengthen metadata, improve event categorization, and support trend identification.

• **Concerns about technology burden**.

Commenters expressed concern that Domain 4, Statement B would be difficult to achieve due to limited technology for transmitting SSEs, precursor events, and near misses to a PSO—especially in states without adverse event reporting laws. CMS clarified that, under the modified requirement, hospitals may attest "yes" without transmitting events to a PSO if they **engage in other patient safety activities** with the PSO. CMS reaffirmed the value of adverse event data collection and analysis, noting the demonstrated safety improvements associated with PSO participation.

Domain 4, Continued

Public Comments: Peer Perspectives, Continued

• **Interaction with larger learning networks**.
Some commenters suggested that submitting information to a PSO could conflict with participation in large-scale learning networks. CMS disagreed, noting that only certain information becomes Patient Safety Work Product (PSWP) under the Patient Safety & Quality Improvement Act (PSQIA), and PSWP protections do not prevent hospitals from engaging with broader learning networks.

• **Relationship to 42 CFR 482.21 (quality assessment & performance improvement).**
One commenter believed the PSSM conflicted with the Conditions of Participation at 42 CFR 482.21, which allow hospitals to:

- Join a PSO;
- Create a PSO; or
- Use non-PSO mechanisms for similar functions.
  CMS clarified that the PSSM does **not** modify 42 CFR 482.21. The regulation continues to require a hospital-wide, data-driven QAPI program and preserves the voluntary nature of PSO participation. Hospitals remain free to work with a PSO, form a PSO, or choose other avenues for safety and quality improvement.

Opportunities for Risk Professionals: Next Steps

1. **Strengthen feedback loops in the event reporting system**
   - ☐ If your event reporting system does not provide feedback to frontline reporters, volunteer to design one—or collaborate with your vendor to build it. A strong feedback loop not only reinforces psychological safety but also prompts leaders to complete investigations more quickly, as staff anticipate closure notifications and follow-up conversations.

Domain 4, Continued

Opportunities for Risk Professionals: Next Steps, Continue

2. **Take a leadership role in your communication & resolution program**
   - ☐ If you are not already a key contributor, position yourself as an essential leader in your organization's communication and resolution (CANDOR-style) program. Consider serving on the early response team, training leaders in early communication practices, and equipping them with disclosure tools. Then take it a step further by leveraging your involvement to report program performance to the governing board, aligning with Domain 4E requirements.
3. **Serve as the organizational expert on Patient Safety Organizations (PSOs)**
   - ☐ Establish yourself as the go-to resource for all PSO-related activity—or partner with another leader to coordinate PSO communications. This is especially important if you manage the event reporting system.
   - ☐ Encourage participation in PSO Safe Tables, which offer valuable insights into harm events across organizations and provide opportunities to proactively mitigate similar risks within your own system. It's also worth noting that, depending on your state regulations, there may be legal protections from being part of a PSO, and it can also improve your data collection and offering insights from throughout your system.
4. **Become the point of contact for collaboratives and learning networks**
   - ☐ Consider volunteering to serve as the primary contact for your organization's patient safety collaboratives or learning networks.
   - ☐ Promote successes and "wins" from these initiatives and integrate them into your broader communication strategy—presenting collaborative achievements alongside patient safety metrics to reinforce progress and sustain engagement.

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Domain 5:
Patient and Family Engagement

The hospital engages patients, families, & caregivers in their own care & co-designs safe systems.

Attestations

5A. Our hospital has a Patient and Family Advisory Council 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.
5B. Our hospital's Patient and Family Advisory Council includes patients and caregivers who are diverse & representative of the patient population.
5C. 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 & linguistically appropriate as well as submit comments for potential correction to their record. (The attestation guide gives examples).
5D. Our hospital incorporates patient and caregiver input about patient safety events (such as patients' submission of safety events, safety signals from patient complaints, or other patient safety experience data, patient reports of discrimination).
5E. 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**.

Domain 5, Continued

Public Comments: Peer Perspectives

For all of these listed challenges, if your hospital is providing patient- and family-centered care, you will be in good standing to meet this Domain. In addition, if you have a difficult patient/family, apply the Reasonable and As Feasible principle to the situation.

- **Involvement of patients, families, and caregivers.**
  A commenter expressed concern that there are situations where involving patients, families, or caregivers would be inappropriate and recommended that Domain 5 be modified so hospitals "should"— rather than "must"—involve them. CMS acknowledged that there may indeed be specific circumstances where such involvement is infeasible or inappropriate. However, CMS clarified that the requirement is not for patients, families, or caregivers to participate in every aspect of hospital operations. Instead, the expectation is that hospitals broadly support family presence and engagement—recognizing family or other designated individuals (as identified by the patient) as essential members of the care team. CMS highlighted that hospitals should encourage involvement in activities such as bedside rounding, shift reports, discharge planning, and 24-hour visitation when feasible.
- **Patient and Family Advisory Councils (PFACs).**
  Several commenters raised concerns about the complexity of creating and maintaining a PFAC, particularly for small hospitals with limited resources. CMS acknowledged that organizations with fewer resources may face challenges in implementing PFACs. However, CMS emphasized that engaging patients, families, and caregivers is a core component of advancing patient safety—and the benefits of this engagement outweigh the associated operational burdens.

Domain 5, Continued

Public Comments: Peer Perspectives, Continued

• **Access to patient information (Domain 5C).**
Some commenters noted that providing patients with access to their health information is already required under the Promoting Interoperability Program and the 21st Century Cures Act. CMS responded that Domain 5C represents a broader approach to patient engagement. Beyond merely providing access, hospitals are expected to support patients with culturally and linguistically appropriate information, as well as assist patients in submitting comments or requests for corrections to their records. CMS emphasized that allowing patients to review and help correct inaccurate or incomplete information is essential to patient safety.

Opportunities for Risk Professionals: Next Steps

1. **Volunteer to lead or serve as a standing PFAC member**
   - ☐ If you are not already involved, consider volunteering to lead or serve as a standing member of the Patient and Family Advisory Council (PFAC) to strengthen patient engagement and safety partnerships.
2. **Re-engage PFACs that paused during the pandemic**
   - ☐ If your PFAC became inactive during the pandemic—as happened in many organizations—take the initiative to help rebuild membership, restart meetings, and reestablish its role in safety and quality improvement.
3. **Use the grievance process to identify potential PFAC members**
   - ☐ If grievance management falls within your responsibilities, look for patients or families who provide thoughtful, constructive feedback and may be ideal candidates for PFAC membership.
4. **Bring patient impact stories to the board**
   - ☐ Share meaningful patient stories with the governing board. If the board is hesitant about having patients or families present, consider framing the story from the patient's perspective using the Institute for Healthcare Improvement (IHI) white paper on effective board governance.

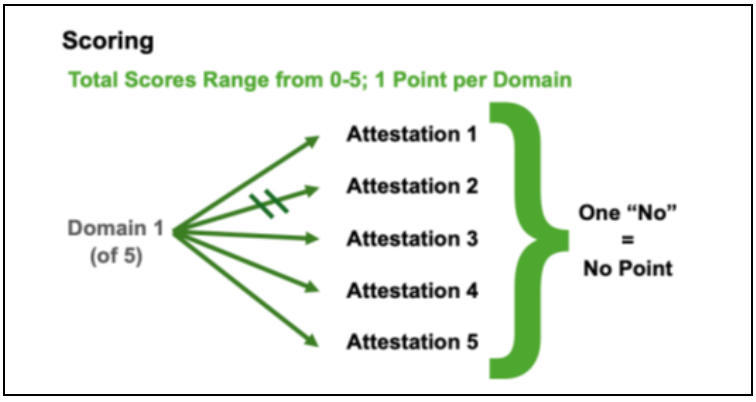
Domain 5, Continued

Opportunities for Risk Professionals: Next Steps, Continued

4. **Bring patient impact stories to the board, Continued**
    - ☐ The IHI paper identifies five core components of quality and safety from the patient's viewpoint:
        a. Provide me with the right care
        b. Keep me safe
        c. Help me stay well
        d. Help me navigate my care
        e. Treat me with respect
            i. White paper link: *https://www.ihi.org/sites/default/files/IHIResearchSummary_EffectiveBo ardGovernanceHealthSystemQuality.pdf*
5. **Serve as a consistent point of contact in the communication & disclosure process**
    - ☐ Take on the role of maintaining ongoing communication with patients and families following an adverse event. Effective communication and resolution are not one-time conversations—they require continuous engagement and follow-through.
6. **Escalate safety signals identified through grievances**
    - ☐ Ensure that recurring themes or emerging trends from patient grievances are elevated to leadership, safety committees, or the Board so they can inform system-level improvements.

Section 3: Risk Considerations

#1. It is an all-or-nothing scoring; any "NO" on an attestation is zero. This is much like the sepsis measure that if you are "no" on one element for a patient, you fail**.**
#2. If a group of hospitals is under one CCN #, the term for the Medicare Provider number, all hospitals must meet all 5 domains & attestations to score positively**.**
#3. CMS intentionally left many terms undefined to maintain flexibility but gave examples in the attestation guide, for example, CMS listed in the attestation guide for a serious safety event is an event judged by the clinical team OR the patient to be "temporary major" or greater harm.
#4. Concerns arose about the reporting will be entered into the NHSN database instead of the Hospital Quality Reporting (HQR) system & that NHSN has traditionally been utilized by infection control & access has been limited. CMS responded that because this is an attestation measure, they felt this was the best system for reporting & noted that CDC, who is responsible for NHSN, has streamlined the registration process for new NHSN users in recent years.
#5. Lastly, some commenters felt there is an added administrative burden with understanding & determining if structures are in alignment with attestation statements. CMS stated they recognize the administrative burden may be greater during the first reporting period, but the benefits of this measure justify its costs.



Section 4: Resource Hub

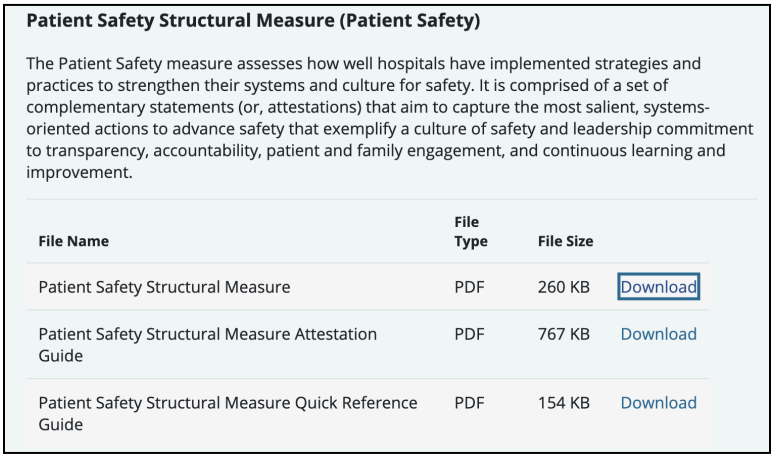
The PSSM is aligned with the IHI/NSC Safer Together: A National Action Plan to Advance Patient Safety, the HHS National Action Alliance for Patient and Workforce Safety, and the CMS National Quality Strategy, and finally the President's Advisors on Science & Technology Report (PCAST). The CMS attestation guide will give much more detail to the attestations in Section 2, including key terms & concepts at the end of the guide, as well as links to the resources. Make sure that if you have previously pulled up the attestation guide, you are working off of Version 2, since this has updates based upon public comments. Within the federal register & the table, there are.

RESOURCE TABLE

- **Patient Safety Structural Measure (PSSM)**
  The first link is the CDC NHSN page, which went live in 2026, the site has a PDF of the attestation list, a PDF that reads like a FAQ with reporting instructions, measure calculation, and an example of of hospital scoring reporting under one CCN#.
  National Healthcare Safety Network.
  https://www.cdc.org/nhsn/psc/pssm.html
- **IHI National Action Plan: Safer Together**
  Includes the National Steering Committee Self-Assessment Tool
  Institute for Healthcare Improvement (IHI).
  https://www.ihi.org/partner/initiatives/national-steering-committee-patient-safety
- **Communication and Optimal Resolution (CANDOR) Toolkit**
  Agency for Healthcare Research and Quality (AHRQ).
  https://www.ahrq.gov/patient-safety/settings/hospital/candor/modules.html
- **AHRQ Patient & Family Engagement Resources**
  https://www.ahrq.gov/topics/patient-and-family-engagement.html
- **AHRQ National Action Alliance for Patient and Workforce Safety**
  National initiative supporting integrated patient + workforce safety efforts.
  https://www.ahrq.gov/action-alliance/index.html
- **National Patient Safety Board (NPSB) – PCAST Report**
  https://npsb.org/resources/pcast-report/
- **PSSM Table**
  Table IX.B.1-02 in the Federal Register (pages 69460 & 69486). Note: footnotes will also take you to resources, such as the National Patient Safety Foundation (NPSF) RCA2 tool & other resources
  https://www.federalregister.gov/d/2024-17021/page-69460
- **ASHRM Forum Blog: Patient Safety Structural Measure (PSSM) Overview**
  https://exchange.ashrm.org/blogs/ashrm-forum/2025/11/25/patient-safety-structural-measure-pssm-a-short-pri

PSSM and PSSM Attestation Guide

Attestation Guide: once this page below opens navigate down to this section and download the Patient Safety Structural Measure and the Patient Safety Structural Measure Attestation Guide:



Patient Safety Structural Measure (Patient Safety)

The Patient Safety measure assesses how well hospitals have implemented strategies and practices to strengthen their systems and culture for safety. It is comprised of a set of complementary statements (or, attestations) that aim to capture the most salient, systems-oriented actions to advance safety that exemplify a culture of safety and leadership commitment to transparency, accountability, patient and family engagement, and continuous learning and improvement.

File Name	File Type	File Size	
Patient Safety Structural Measure	PDF	260 KB	Download
Patient Safety Structural Measure Attestation Guide	PDF	767 KB	Download
Patient Safety Structural Measure Quick Reference Guide	PDF	154 KB	Download

Or consider utilizing the IHI's self assessment, noting that it does not follow the same format as the PSSM itself.

FOUNDATIONAL AREA: Culture, Leadership, and Governance	
SCORE:	**Element Criteria – 1. Goals and Strategy:**
Unsure	Do not know or not aware of
Score 0	Does not meet Score 1
Score 1- Beginning *Must meet all Score 1 Criteria*	• **Some Goals:** Some organizational patient safety goals exist; however, they are not clearly aligned in strategic and operational plans.
Score 2 – Making Progress *Must meet all Score 2 Criteria*	• **Strategic and Operational Plans:** Patient safety goals are clearly articulated in strategic and operational plans that encompass all types of care settings served. • **Action Plan and Metrics:** Each patient safety goal is accompanied by an action plan and associated metrics to drive continuous improvement.
Score 3 – Significant Impact *Must meet all Score 2 and 3 Criteria*	• **Senior Sponsor:** Each patient safety goal has a dedicated senior sponsor who champions the work, monitors progress, ensures corrective action plans are created when goals are not met, and advocates to ensure resources are available as needed. • **Budgeted Resources:** The organization's budget ensures adequate resources for the patient safety strategy, including equipment, systems, and personnel.
Score 4 – Exemplary *Must meet all Score 2, 3, and 4 Criteria*	• **Zero Preventable Harm:** The organization commits to safety, including the ultimate goal of "zero preventable harm" to patients. The safety commitment is visible publicly. • **Integration with Health Equity:** The organization integrates patient safety strategies with initiatives for advancing health equity.

(https://www.ihi.org/self-assessment-tool-national-action-plan-advance-patient-safety)

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Section 5: Role- and Setting-Based Variations

The CMS Patient Safety Structural Measure (PSSM) is intentionally flexible, recognizing that hospitals differ widely in size, complexity, governance models, and resources. This section highlights how expectations may be *operationalized differently* across roles and settings while still meeting the measure's structural intent.

Small, Rural, and Resource-Constrained Hospitals

For smaller or rural hospitals, PSSM compliance does not require creating entirely new structures; rather, it requires **demonstrating intentionality and accountability** using existing resources.

Key considerations include:

- Leveraging **dual-role leaders** (e.g., a single leader overseeing quality, safety, and risk) with clearly documented responsibilities
- Using **simplified governance structures** that still show executive and board-level oversight of patient safety
- Demonstrating safety culture through **regular leadership engagement**, staff feedback mechanisms, and learning from events, even if formal programs are smaller in scale
- Clearly documenting how patient safety priorities are set, reviewed, and acted upon, even when teams are lean

The focus should be on clarity, consistency, and leadership engagement—not organizational size.

System-Level and Multi-Hospital Risk Leaders

Health systems and multi-hospital organizations must balance **local accountability** with **system-level oversight.** PSSM expectations apply at the hospital level, but CMS recognizes the role of system governance in supporting safety infrastructure. System-level leaders should consider:

- Clearly delineating **which safety structures are centralized** and which are locally owned
- Ensuring each hospital can demonstrate **site-specific leadership accountability**, even when policies or committees are system-wide

- Aligning PSSM domains with **enterprise risk management (ERM)**, system quality strategies, and board reporting
- Standardizing tools, policies, and reporting where possible, while allowing flexibility for local implementation

Strong system oversight should enable, not obscure, hospital-level responsibility for patient safety.

Operational vs. Enterprise Risk Perspectives

The PSSM bridges operational patient safety work and enterprise risk oversight. Understanding this distinction helps organizations demonstrate both execution and governance.

From an **operational risk and safety lens,** emphasis is placed on:

- Day-to-day safety practices and reporting
- Frontline engagement and learning from events
- Implementation of safety processes and improvement actions

From an **enterprise risk lens**, emphasis shifts to:

- Governance structures, escalation pathways, and accountability
- Executive and board visibility into patient safety risks
- Integration of patient safety into strategic planning and risk prioritization

Effective PSSM implementation connects these perspectives, showing how frontline safety insights inform leadership decisions and how leadership commitment shapes safety culture.

Key Takeaway

Regardless of role or setting, CMS's expectation is not uniformity of structure, but **alignment of intent.** Hospitals must be able to show that patient safety is deliberately led, supported, and governed in a way that fits their organization while meeting the core principles of the PSSM.