Patients For Patient Safety US

The Safe Healthcare System Patients Deserve

A Call to CMS from the Patient Community to Make Patient Safety a Foundational Priority

A quarter of a century after *To Err Is Human*, the landmark national call to action on patient safety, preventable patient harm remains a leading cause of death and disability in the United States. Despite extraordinary advances in science, technology, and treatment, approximately 25% of patients in the United States continue to experience harm in healthcare, with older adults, mothers, people with disabilities, and people with rare diseases among those at heightened risk. Missed, wrong, or delayed diagnoses contribute to death or serious disability for an estimated 900,000 to 1.2 million patients annually. And fewer than half of hospital patient harm events are captured by systems intended to identify and learn from them.

The message is clear: the healthcare system has not yet achieved the systemic safety culture that *To Err Is Human* envisioned—and that patients deserve.

The problem is not simply that harm occurs. It is that our healthcare system continues to underinvest in the organizational capabilities, infrastructure, and accountability needed to prevent it.

Too often, patient safety efforts focus on identifying adverse events after they happen, rather than proactively identifying risks, strengthening systems, and preventing harm before it reaches patients. Accountability is frequently tied to isolated outcomes instead of the leadership, workforce, culture, processes, and patient engagement that make safe care possible.

Yet improvement is achievable. We have seen organizations reduce harm when leaders make safety a priority, adopt evidence-based practices, create environments where concerns can be raised without fear, and listen to patients and families.

Patients have waited too long for a healthcare system that puts safety first. We have an opportunity to change that now.

A National Opportunity: From Measuring Harm to Preventing Harm

The August 19, 2026 report from the HHS Physician-Focused Payment Model Technical Advisory Committee (PTAC), Targeting Improvements in Patient Safety Through Alternative Payment Models, provides an important opportunity to advance this transformation.

PTAC calls for a future in which the goal is zero preventable harm and patient safety is proactive, preventive, and focused on system-wide improvement. It emphasizes that CMS and the Department of Health and Human Services should use all available policy levers—including Conditions of Participation, payment and coverage policies, quality measurement, and Quality Improvement Organizations—to accelerate patient safety improvement.

Importantly, PTAC recognizes that patients and families are an essential, but underutilized, source of safety intelligence. It calls for patient-reported safety measures to be developed, tested, and implemented, including as a key component of value-based payment.

The report also recognizes the work of Patients for Patient Safety US (PFPS US) and Project PIVOT, including the proposed PIVOT Earn-Back Value Model. This is an important acknowledgment that patient-defined measures and payment incentives can be used together to drive measurable improvements in safety.

CMS now has an opportunity to translate this direction into action.

PFPS US calls on CMS to make patient safety a foundational expectation of its National Quality Strategy and to operationalize that commitment through three complementary strategies:

- Strengthen organizational capabilities and structural accountability so that every healthcare organization has the systems and leadership commitment needed to keep patients safe.
- Make the patient experience an essential source of safety intelligence by modernizing patient-reported measures and capturing harms, near misses, diagnostic errors, and failures in communication and care coordination.
- Align payment, technology, and quality improvement infrastructure to reward transparency, learning, investment, and measurable improvements in patient safety.

These strategies are interdependent. Structural expectations establish the foundation for safe care. Patient-reported measures help determine whether that foundation is working. Payment and improvement mechanisms provide the resources and incentives to strengthen it.

1. Strengthen the Organizational Capabilities to Keep Patients Safe

PFPS US calls on CMS to elevate patient safety from an aspirational quality goal to a fundamental organizational responsibility.

CMS's Patient Safety Structural Measure (PSSM) and Age-Friendly Hospital Measure (AFHM) represent an important shift toward assessing the organizational structures, leadership, policies, culture, and practices that support safe care.

Rather than relying exclusively on retrospective measures of adverse events, structural measures assess whether healthcare organizations have the foundational capabilities to prevent harm and continuously improve.

PFPS US calls on CMS to:

- Elevate the PSSM and AFHM into Medicare Conditions of Participation (CoPs) so that foundational expectations for patient safety, leadership accountability, and age-friendly care become integral to hospital participation in Medicare.
- Strengthen expectations for executive and board-level accountability for patient safety, including the resources and infrastructure necessary to identify and mitigate risks.
- Promote a culture of transparency, psychological safety, and continuous learning in which patients, families, and healthcare professionals can raise concerns and report near misses without fear of retaliation.
- Ensure that patients and families are meaningfully involved in organizational safety committees, improvement initiatives, and the development of patient safety strategies.

Making these structural expectations part of the regulatory framework would help ensure that patient safety is not left to voluntary adoption or variable organizational priorities. It would establish organizational capability as a foundation for safe care.

2. Make the Patient Experience an Essential Source of Safety Intelligence

The healthcare system cannot know whether patients are safe if it does not systematically ask them.

Traditional patient experience and satisfaction surveys have not adequately captured the safety issues that matter most to patients and families. Many of the most consequential failures—including missed or delayed diagnoses, communication breakdowns, dismissal of patient concerns, and failures in care coordination—may not be visible in claims data, medical records, or conventional adverse-event reporting systems.

Patients and families often recognize these failures first. Their experiences can reveal risks and breakdowns across the full continuum of care, including events that occur between appointments, across care settings, and during transitions.

PTAC reinforces this point, calling for standardized mechanisms to collect patient-reported safety information and for patient-reported experience and outcome measures to become part of CMS's safety measurement and value-based payment strategy.

PFPS US calls on CMS to:

- Modernize standardized patient experience surveys to capture the safety information that matters most to patients and families, including harms and near misses, missed or delayed diagnoses, communication failures, failures in care coordination, and dismissal of patient concerns.
- Develop, test, and implement patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) that capture safety across the patient journey and across care settings.
- Integrate patient-reported safety information with clinical, claims, and other safety data to provide a more comprehensive and longitudinal understanding of risk and harm.
- Use technology-enabled reporting approaches that make it easier for patients and families to share safety concerns in real time, while providing accessible options for people who cannot or prefer not to report digitally.
- Establish clear expectations that patient-reported concerns will be acknowledged, investigated when appropriate, and used to drive improvement—with appropriate protections for privacy and confidentiality.
- Include patients and families in the design, testing, and implementation of patient safety measures and improvement strategies.

Patient-reported measures are not simply another source of satisfaction data. They are an essential source of safety intelligence—one that can make otherwise invisible risks visible and help organizations identify where systems are failing patients.

3. Align Payment, Technology, and Quality Improvement to Reward Prevention and Improvement

Healthcare organizations need more than measurement and accountability. They need the resources, incentives, and technical support to build systems that prevent harm.

PTAC identifies a critical problem with current approaches: organizations may face financial penalties for adverse events without receiving meaningful support or incentives to invest in the systems needed to prevent future harm. A punitive approach can discourage reporting and reinforce a culture of concealment rather than transparency and learning.

CMS has an opportunity to use its purchasing power to change these incentives.

PFPS US calls on CMS to:

- Make patient safety a core requirement across existing Alternative Payment Models (APMs) and consider new safety-focused models that reward proactive risk identification, system improvement, and measurable reductions in preventable harm.
- Advance the PIVOT Earn-Back Value Model, which links patient-reported measures to a two-sided risk payment approach. Under this model, funds withheld for failure to meet established performance benchmarks are placed in a Performance Reserve Account. Healthcare organizations can earn back funds by demonstrating measurable improvements in patient-defined safety and experience outcomes.
- Provide upfront resources and technical assistance to help healthcare organizations—particularly small, rural, and under-resourced providers—adopt the technology, workforce capabilities, and infrastructure needed for continuous safety improvement.
- Use CMS Quality Improvement Organizations (QIOs), including Beneficiary and Family Centered Care QIOs (BFCC-QIOs), to support organizations in identifying risks, responding to patient-reported concerns, and implementing evidence-based improvements.
- Accelerate the responsible use of digital technologies and artificial intelligence to identify safety signals, detect patterns of risk, support timely interventions, and enable continuous learning.
- Advance standardized data infrastructure and interoperability so that patient safety information can be shared and analyzed across care settings and throughout the patient journey.

The PIVOT Earn-Back model offers a practical example of how payment policy can reinforce a culture of safety. Rather than relying solely on financial penalties for poor performance, it creates an opportunity for organizations to recover withheld funds by demonstrating that they have addressed underlying problems and improved outcomes that matter to patients.

The objective is not simply to penalize harm. It is to make investment in preventing harm the better organizational and financial decision.

Let's Seize This Moment

The August 2026 PTAC report makes clear that the tools and policy levers to accelerate patient safety improvement already exist. CMS has an opportunity to bring them together in a coordinated national strategy—one that moves beyond counting adverse events to building the organizational capabilities, measurement systems, data infrastructure, and payment incentives needed to prevent harm.

Patients and families must be central to this transformation. Their experiences are not peripheral perspectives; they are essential evidence about whether healthcare is safe.

PFPS US invites patients, families, healthcare organizations, policymakers, and all who share this vision to join this national call to action.

Together, we can move from measuring harm to preventing harm—and make safe care a foundational expectation for every patient, in every healthcare setting.

Patients Deserve Nothing Less.

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