CMS Patient Safety Structural Measure

On August 1, 2024, the Centers for Medicare & Medicaid Services released a new Patient Safety Structural Measure for acute care hospitals. This measure is included in the _Medicare/Medicaid/CHIP Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes for Fiscal Year 2025_ final rule.

Why did CMS include a Patient Safety Structural Measure in its 2025 final rule?

Recognizing that, despite past progress, patient harm still occurs at significant rates, CMS is looking to assess how well hospitals have implemented strategies and practices to build safety culture and strengthen safety systems. Through reporting and public transparency incentives, CMS seeks to motivate hospital leaders to increase their investment in safety culture and systems.

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.

On what patient safety domains will hospitals be measured?

The rule calls for each covered hospital to attest to how its structures and cultures prioritize patient safety across five domains that are known to support safety improvement:

1. Leadership commitment to eliminating preventable harm

2. Strategic planning and organizational policy

3. Culture of safety and learning health systems

4. Accountability and transparency

5. Patient and family engagement

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 will start 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.

CMS Patient Safety Structural Measure Domains

Attestation domains	Attestation statements: Attest yes or no to each statement *(Note: Affirmative attestation of all statements within a domain would be required for the hospital to receive a point for the domain.)*
Domain 1: Leadership commitment to eliminating preventable harm	
The senior leadership and governing board at hospitals set the tone for commitment to patient safety. They must be accountable for patient safety outcomes and ensure that patient safety is the highest priority for the hospital. While the hospital leadership and the governing board may convene a board committee dedicated to patient safety, the most senior governing board must oversee all safety activities and hold the organizational leadership accountable for outcomes. Patient safety should be central to all strategic, financial, and operational decisions.	A. Our hospital senior governing board prioritizes safety as a core value, holds hospital leadership accountable for patient safety, and includes patient safety metrics to inform annual leadership performance reviews and compensation. B. Our hospital leaders, including C-suite executives, place patient safety as a core institutional value. One or more C-suite leaders oversee a system-wide assessment on safety (examples provided in the Attestation Guide), and the execution of patient safety initiatives and operations, with specific improvement plans and metrics. These plans and metrics are widely shared across the hospital and governing board. C. Our hospital governing board, in collaboration with leadership, ensures adequate resources to support patient safety (such as equipment, training, systems, personnel, and technology). D. Reporting on patient and workforce safety events and initiatives (such as safety outcomes, improvement work, risk assessments, event cause analysis, infection outbreak, culture of safety, or other patient safety topics) accounts for at least 20% of the regular board agenda and discussion time for senior governing board meetings. E. C-suite executives and individuals on the governing board are notified within 3 business days of any confirmed serious safety events resulting in significant morbidity, mortality, or other harm.
Domain 2: Strategic planning and organizational policy	
Hospitals must leverage strategic planning and organizational policies to demonstrate a commitment to safety as a core value. The use of written policies and protocols that demonstrate patient safety is a priority and identify goals, metrics, and practices to advance progress, is foundational to creating an accountable and transparent organization. Hospitals should acknowledge the ultimate goal of zero preventable harm, even while recognizing that this goal may not be currently attainable and requires a continual process of improvement and commitment. Patient safety and equity in care are inextricable, and therefore equity, with the goal of safety for all individuals, must be embedded in safety planning, goalsetting, policy, and processes.	A. Our hospital has a strategic plan that publicly shares its commitment to patient safety as a core value and outlines specific safety goals and associated metrics, including the goal of "zero preventable harm." B. Our hospital safety goals include the use of metrics to identify and address disparities in safety outcomes based on the patient characteristics determined by the hospital to be most important to health care outcomes for the specific populations served. C. 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, and reckless behavior. D. Our 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. E. Our hospital has an action plan for workforce safety with improvement activities, metrics and trends that address issues such as slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, fire/electrical safety, and psychological safety.
Domain 3: Culture of safety and learning health systems	
Hospitals must integrate a suite of evidence-based practices and protocols that are fundamental to cultivating a hospital culture that prioritizes safety and establishes a learning system both within	A. Our hospital conducts a hospital-wide culture of safety survey using a validated instrument annually, or every 2 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.

and across hospitals. These practices focus on actively seeking and harnessing information to develop a proactive, hospital-wide approach to optimizing safety and eliminating preventable harm. Hospitals must establish an integrated infrastructure (that is, people and systems working collaboratively) and foster psychological safety among staff to effectively and reliably implement these practices.

B. Our hospital has a dedicated team that conducts event analysis of serious safety events using an evidence-based approach, such as the National Patient Safety Foundation's Root Cause Analysis and Action (RCA2).

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

D. Our hospital implements a minimum of 4 of the following high reliability practices:
- Tiered and escalating (for example, unit, department, facility, system) safety huddles at least 5 days a week, with 1 day being a weekend, that include key clinical and non-clinical (for example, lab, housekeeping, security) units and leaders, with a method in place for follow-up on issues identified.
- Hospital leaders participate in monthly rounding for safety on all units, with C-suite executives rounding at least quarterly, with a method in place for follow-up on issues identified.
- A data infrastructure to measure safety, based on patient safety evidence (for example, systematic reviews, national guidelines) and data from the electronic medical 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 a computerized physician order entry system and a barcode medication administration system, that promote 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, Plan-Do-Study-Act, and/or high reliability frameworks.
- Team communication and collaboration training of all staff.
- The use of human factors engineering principles in selection and design of devices, equipment, and processes.

E. Our hospital participates in 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 4: Accountability and transparency

Accountability for outcomes, as well as transparency around safety events and performance, represent the cornerstones of a culture of safety. For hospital leaders, clinical and nonclinical 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.

A. Our hospital has a confidential safety reporting system that allows staff to report patient safety events, near misses, precursor events, unsafe conditions, and other concerns, and prompts a feedback loop to those who report.

B. Our hospital voluntarily works with a Patient Safety Organization 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.

C. Patient safety metrics are tracked and reported to all clinical and non-clinical staff and made public in hospital units (for example, displayed on units so that staff, patients, families, and visitors can see).

D. Our hospital has a defined, evidence-based communication and resolution 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
	E. 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.

Domain 5: Patient and family engagement	
The effective and equitable engagement of patients, families, and caregivers is essential to safer, better care. Hospitals must embed patients, families, and caregivers as coproducers of safety and health through meaningful involvement in safety activities, quality improvement, and oversight.	A. 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.
	B. Our hospital's Patient and Family Advisory Council includes patients and caregivers of patients who are diverse and representative of the patient population.
	C. Patients have comprehensive access to and are encouraged to view their own medical records and clinician notes via patient portals and other options, and the hospital provides support to help patients interpret information that is culturally and linguistically appropriate as well as submit comments for potential correction to their record.
	D. Our hospital incorporates patient and caregiver input about patient safety events or issues (such as patient submission of safety events, safety signals from patient complaints or other patient safety experience data, patient reports of discrimination).
	E. Our hospital supports the presence of family and other designated persons (as defined by the patient) as essential members of a safe care team and encourages engagement in activities such as bedside rounding and shift reporting, discharge planning, and visitation 24 hours a day, as feasible.

Source: Department of Health and Human Services

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