PSSM is here!

The what, when, and how of CMS's new Patient Safety Structural Measure

March 13, 2025

MONTHLY INSIGHTS

Webinar schedule & topics

THE 3RD THURSDAY OF EVERY MONTH:

10AM Pacific, 1PM Eastern

TODAY

PSSM is here! The what, when, and how of CMS's new Patient Safety Structural Measure

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MARCH

Boosting Practitioner Performance: Key Trends and Opportunities

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Navigating the Zoom interface

Handouts:

Check the chat function for copies of the slides for note taking and any other handouts.

Questions and comments:

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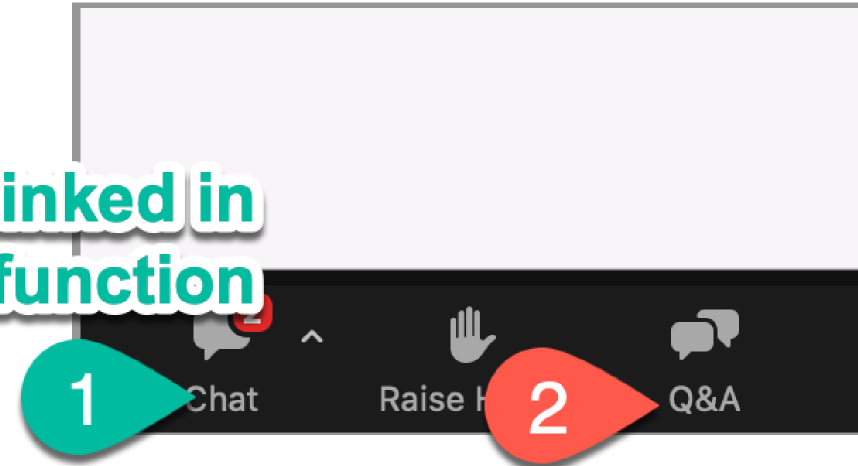

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28 RESULTS

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LIVE WEBINARS

3rd Thursday of (almost) every month

Boosting practitioner performance: Key trends and opportunities

department can partner to effectively employ proven strategies to manage practitioner performance.

Don't fall into the QAPI trap: Avoid significant CMS sanctions while improving performance and safety

This webinar will give you the tools to survive surveyor scrutiny by shoring up common QAPI vulnerabilities.

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Healthcare challenges are not siloed. *Neither are we.*

Chartis has **six lines of business** that together craft **singular solutions**.

- 1000+ Professionals
- Mission: to materially improve healthcare
- Ranked Best Overall Management Consulting Firm by KLAS
- Chartis acquires Greeley in 2019
- Greeley brand brought back in 2024 to cover Medical Staff Services Related Offerings and now part of Clinical Transformation

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High Reliability Care

UNPARALLELED BREADTH AND DEPTH

Our clients are all striving toward the same goal of providing safe, high-quality care—something that's becoming even more important with the many distractions and disruptions in healthcare today. We help clients achieve their organizational reliability, quality, and safety goals, leading to results in areas that matter most—improved care outcomes, staff engagement, operational stability, and total cost of care, enhanced reputation, and better patient experience.

High Reliability Organization (HRO)

- High reliability organizational design and infrastructure
- Quality, Value, and Performance Improvement
- Quality ratings and rankings optimization
- Patient safety / harm reduction / safety and reliability culture
- Adverse event response and remediation / RCA
- High fidelity measurement / Clinical Documentation Integrity (CDI)
- Care facilitation

Clinical Compliance, Regulatory, and Physical Environment Solutions

- Adverse event response
- Adverse action regulatory response and remediation
- Accrediting body readiness assessment
- Regulatory readiness rehearsal / mock surveys
- Life safety and environment of care assessment
- Policy simplification
- Infection prevention program

Bylaws, Rules and Regulations, and Peer Review

- Bylaws and rules and regulations assessment and redesign
- Peer review assessment and redesign
- Medical staff / medical director structure and governance
- Credentialing, OPPE

External Peer Review

- Physician/advanced practice professional external peer review
- Focused Professional Practice Evaluation (FPPE)
- Ongoing case review in support of OPPE/FPPE
- Medical necessity reviews
- Patient safety/care quality case reviews

MEMBERSHIP AND PROFESSIONAL EDUCATION SERVICES

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What is your *role*?

- Chief Quality Officer
- Other Executive Leader
- Quality Manager
- Patient Safety Officer
- Risk Manager
- Accreditation/Regulatory Compliance
- Consultant
- Other

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Who is your *primary accreditor*?

- The Joint Commission
- The Accreditation Commission for Health Care (ACHC)
- Det Norske Veritas (DNV)
- Center for Improvement in Healthcare Quality (CIHQ)
- Non-Accredited
- Other

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What do you know today about the new CMS *structural measure*?

Today is my first exposure to the topic

I heard it was coming but know nothing about it

We’ve started to prepare but have a long way to go to be ready

We’re ready to go!

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Happy Patient Safety Awareness Week!

Today's *discussion*

An introduction into the new CMS Patient Safety Structural Measure for FY2025 including actions to be taken by hospitals and healthcare systems.

Jamelle Skelton, MSN, HACP-CMS, AHPCP

Senior Consultant,
High Reliability Care & Compliance

Steve Mrozowski, MHA, CPPS, FACHE

Partner,
High Reliability Care

"

Keeping up with change, planning for tomorrow

Learning objectives

1. Describe how to connect your current culture of safety activities with the new CMS requirements
2. List key activities for hospital and health system leaders on how to advance basic compliance into sustained progress in the reduction of harm to patients, staff members, and visitors
3. Define upcoming attestation deadlines and how to meet them

- founded, 1802
- first work rules for safety, 1811
- machinery to replace workers, 1850
- safety committees, 1911
- safety statistics, 1912
- safety promoted as priority, 1920

> …all injuries ultimately reflected a failure of leadership."
>
> — *Louis DeBlois 1919*

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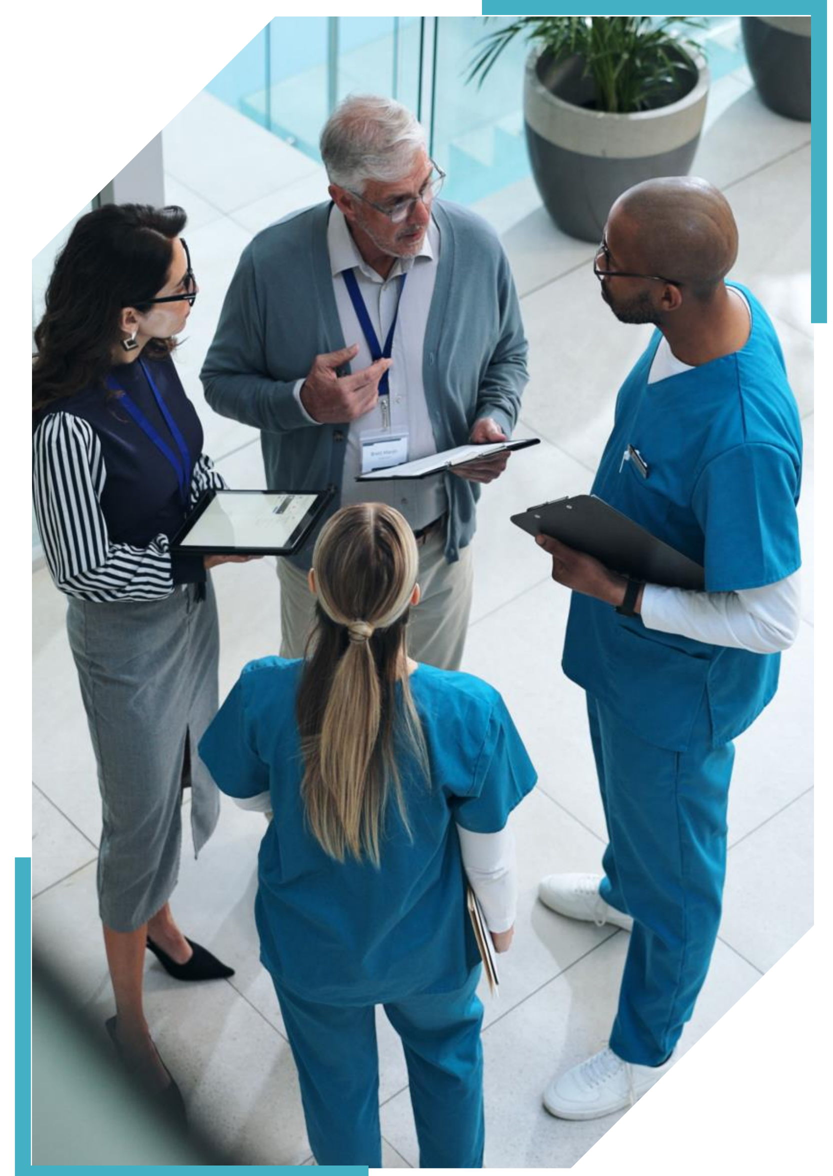
What must healthcare leaders know

- CMS has introduced 5 attestation-based domains (25 elements total) embedded within a new patient safety structural measure to reinforce practices to strengthen foundational elements of safe care
- Applicable to acute care hospitals that participate with CMS quality reporting and PPS-exempt cancer centers
- **Focus on structure, environment of care, and administrative processes and policies**
  - **Different from typical outcome focus of other measures**
  - **Provides a unique opportunity to embrace the "spirit" of the standard**



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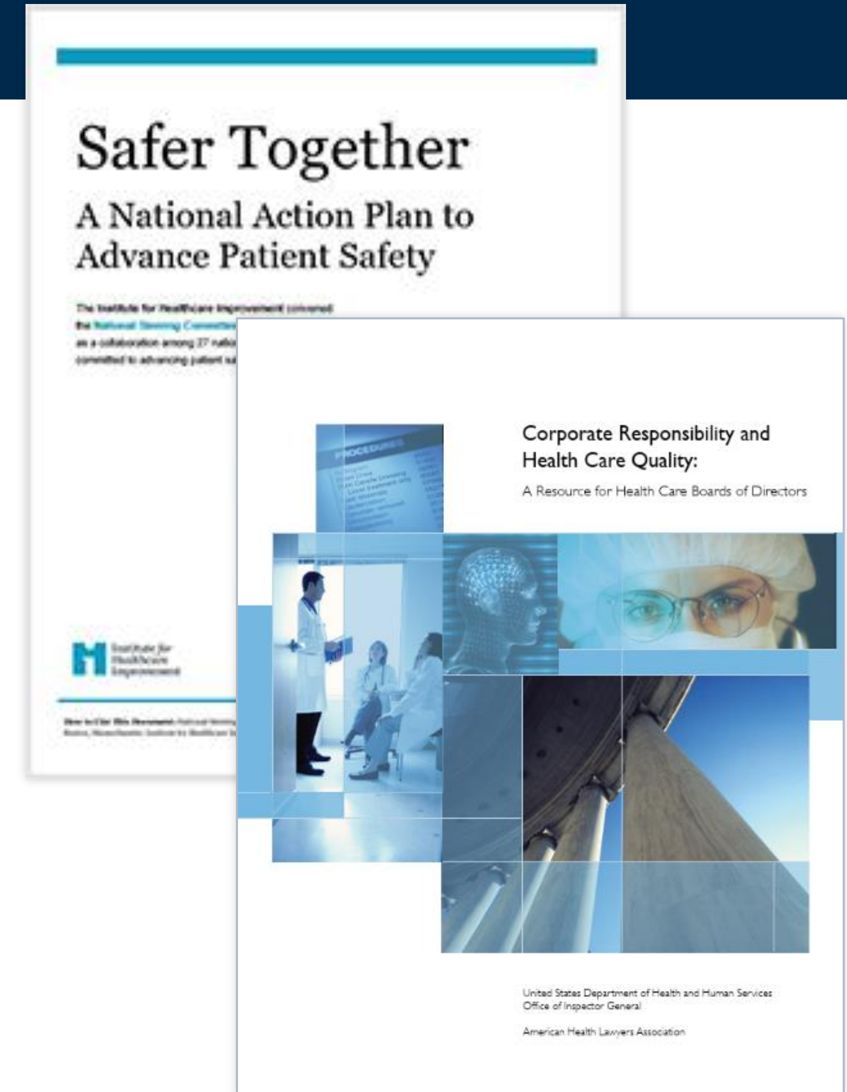
Close alignment

- *Safer Together: A National Action Plan to Advance Patient Safety* informed the new PSSM
  - National Steering Committee for Patient Safety
    - Co-formed by the IHI and ACHE
  - Seventeen key recommendations
  - Self-assessment tool for healthcare organizations
  - Download here: https://www.ihi.org/national-action-plan-advance-patient-safety
- OIG Reports
  - Quality and patient safety are inextricably linked to compliance
  - OIG and DOJ have investigated many cases of significantly substandard care resulting in harm
  - Focus on board oversight, clear connection to compliance, and conducting robust cause analysis



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1 Leadership commitment to eliminating preventable harm

Addresses the importance of senior leadership and the governing body in setting the tone for commitment and the essential leadership practices.

5 Patient and family engagement

Supports the effective and equitable engagement of patients, families, and caregivers into their own care and co-design of system safety.

THE MEASURE

2 Strategic planning and organizational policy

Addresses how hospitals use their strategic planning cycles and internal policies to demonstrate the commitment to safety.

4 Accountability and transparency

Ensures accountability for outcomes and transparency around safety events.

3 Culture of safety and learning health system

Addresses whether hospitals integrate evidence-based practices to cultivate a safety culture and learning system that span across facilities and sites of care.

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Leadership commitment

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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.

- 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.
- 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**, 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.
- Our hospital governing board, in collaboration with leadership, ensures adequate resources to support patient safety (such as equipment, training, systems, personnel, and technology).
- Reporting on patient and workforce safety events and initiatives accounts for **at least 20% of the regular board agenda** and discussion time for senior governing board meetings.
- C-suite executives and individuals on the governing board are notified **within 3 business days** of any confirmed serious safety events resulting in significant harm

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The role of the physician leader

Already foundational

Current CMS COP – The hospital must have an organized medical staff – responsible for the quality of care provided to patients.

Liaison to the Board

Physician leaders on your board, or as invited guests, can help translate the details of clinical quality initiatives and lobby for resources

Deference to expertise

Those who do the work each day at the sharp end are likely the best source of risk identification and proposed mitigation tactics

ACTIVELY partner on Unit-Based and Domain Teams

Physician leaders cannot maintain a passive role or delegate participation – should have a personal and professional interest in patient safety

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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 identifying 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, must be embedded in safety planning, goalsetting, policy, and processes.

- 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."
- 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.
- 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.
- 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 with regular assessments of these competencies.
- 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.

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High Reliability Care leading practice framework

A high reliability quality and safety program requires an organization-wide, equity-informed commitment to outcomes and shared accountability.

Alignment & accountability

Create an integrated approach that organizes provider, quality, patient safety, and clinical operations structures to foster communication, alignment, and accountability from the Board to the front line

Measurement & technology

Leverage best practice tools to support risk stratification, performance and clinical documentation improvement, point of care decision making, data collection, reporting, and incident management

Clinical & operational processes

Promote reliability and resilience through effective care design, measurement, harm detection, and continuous improvement across sites of care

Leadership, people & culture

Attain optimal performance through model leadership behavior, training and development strategies, and interventions that support psychological safety, culture, and engagement

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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 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.

↗ 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 .

↗ 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).

↗ Our hospital has a patient safety metrics dashboard and uses external benchmarks to monitor performance and inform improvement activities on safety events.

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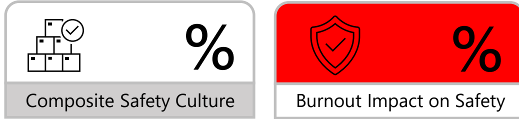
WELLNESS BURNOUT DASHBOARD

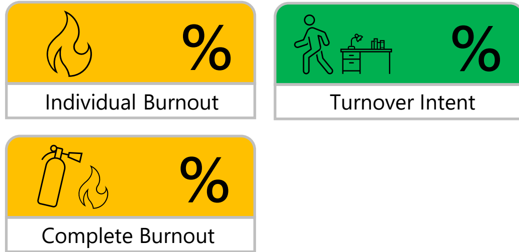
June 2024

Health System X
Hospital B: Inpatient – Critical Care Nursing
Total N = 294

Key Safety and Composite Outcomes



Burnout and Wellbeing Outcomes



LEGEND

- Favorable or excellent
- In satisfactory or good range
- Concerning or emerging
- Focus to improve

SOPS Hospital Survey 2.0

Chartis Burnout and Wellness Survey

05 Joy

Measure	Value
Joy at Work	%
Impact Patients	%
Impacted by Patient Suffering	%

04 Appreciation & Connection

Measure	Value
Admin Support for Patient Safety	%
Supervisor Support for Safety	%
Response to Error	%
Communication Openness	%
Does Not Feel Valued by Organization	%
Feels Unappreciated (Hospital Leaders)	%
Does Not Share Supervisor's Values	%
Feels Unappreciated (Supervisor)	%

03 Respect

Measure	Value
Teamwork	%
Staffing and Work Pace	%
Civility	/5
Avg Hours Work per Week	##.##
Fair Accountability	%
Poor Doc-Nurse Interaction	%
Poor APP-Nurse Interaction	%
EMR Satisfaction	%

02 Safety

Measure	Value
Handoffs and Info Exchange	%
Org Learning & Continuous Improve	%
Reporting Safety Events	%
Communication about Error	%
Not Safe Inside the Building	%
Not Safe Outside of the Building	%
Daily Interruptions	%
Physical Assaults (Patients)	%
Verbal Assaults (Patients)	%
Treated Differently (Patients)	%

01 Basics

Measure	Value
Dehydrated	%
Skipping Meals	%
Holding Urine	%
Easy Access to Water	%
Easy Access to Food	%
Poor Sleep	%
Has a PCP	%
Physical Stress	%
Sadness	%
Physical Pain	%
Isolation	%
Risky Alcohol Use	%

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Our hospital implements a minimum of 4 of the following practices:

- Tiered and escalating safety huddles at least 5 days a week, with 1 day being a weekend, that include key clinical and non-clinical units and leaders, with a method in place for follow-up.
- 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 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 and the governing board.
- Technologies, including a computerized physician order entry system and a barcode medication administration systems.
- The use of a defined improvement method, such as Lean, Six Sigma, PDSA, or HRO frameworks.
- The use of human factors engineering principles in selection and design of devices, equipment, and processes.

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

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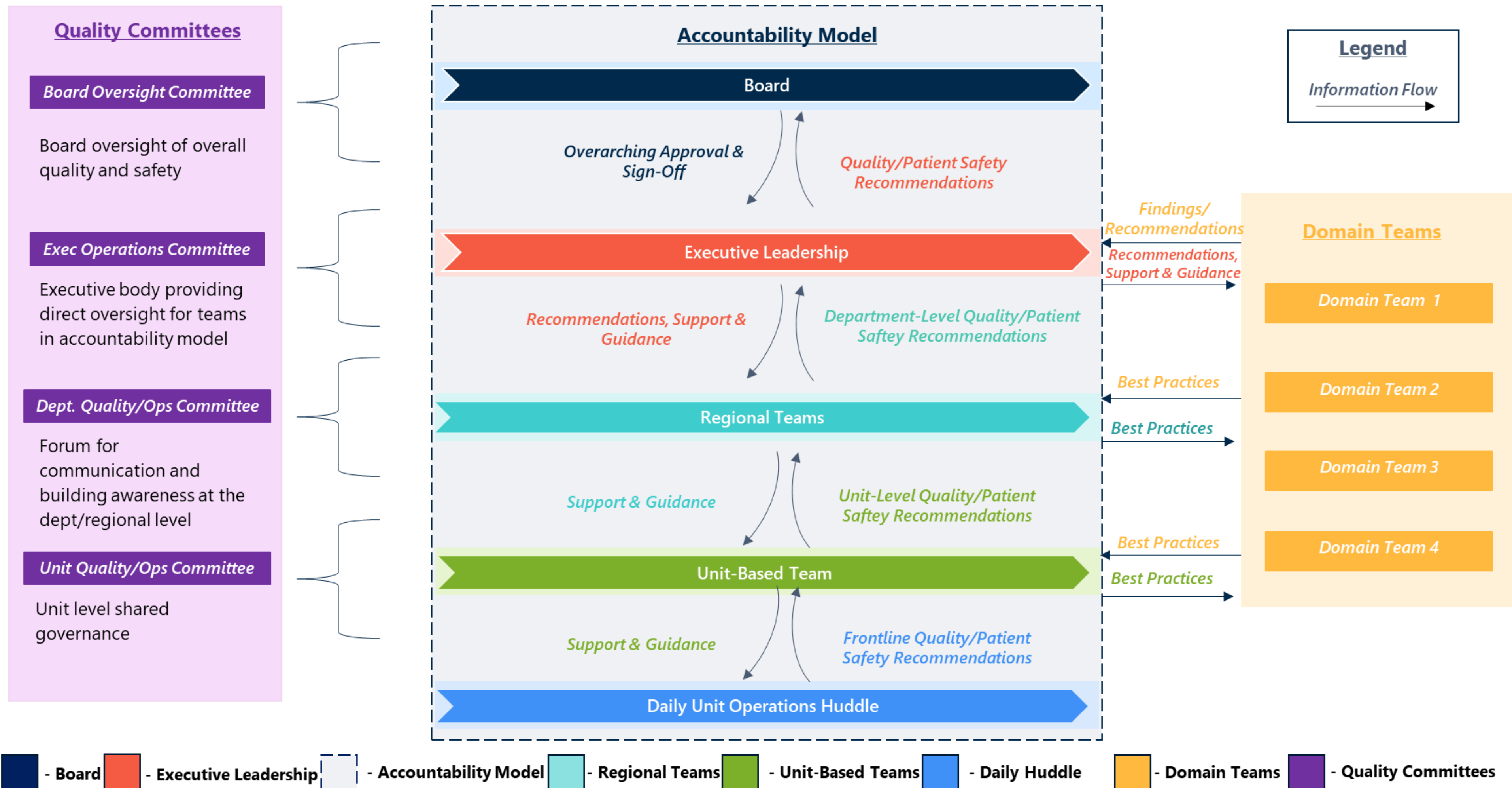
Alignment and Accountability Model

CONCEPTUAL STRAW MODEL



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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.**

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 voluntarily works with a **Patient Safety Organization** listed by AHRQ to carry out patient safety activities such as the collection and analysis of patient safety work product, and dissemination of information, encouraging a culture of safety.

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).

Our hospital has a defined, evidence-based **communication and resolution program** reliably implemented after harm events that contain event identification, ongoing communication, investigation information, care for caregiver, financial (and non) reconciliation, and ongoing family 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.

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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.

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 improvements.

Our hospital's Patient and Family Advisory Council includes patients and caregivers of patients who are **diverse and representative of the patient population**.

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.

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).

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, shift reporting, discharge planning, and visitation 24 hours a day.

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Patient and family involvement

Leapfrog's Policy on Never Events

Beginning in 2007, Leapfrog asks hospitals to commit to five actions if a never event occurs within their facility: 1) apologize to the patient; 2) report the event; 3) perform a root cause analysis; 4) waive costs directly related to the event; 5) provide a copy of the hospital's policy on never events to patients and payors upon request. In 2017, Leapfrog asked hospitals to commit to four additional actions: 6) interview patients and/or families to gather evidence for the root cause analysis; 7) inform patients and/or families of actions taken to prevent reoccurrence of the event; 8) provide support for caregivers involved in the event; and 9) perform an annual review to ensure compliance with each of these elements for each event.

- PFACs have been a longstanding practice
  - Recently/post-Covid discussion on reducing those committees or limiting scope to mitigate risks of discovery and claims
- Expand scope to be more than previewing forms, signage, and picking out color-schemes
- Spirit of requiring family participation in RCAs extends beyond initial questions or disclosure – should be meaningful

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So now what…

Things you can do starting *NOW*

01

Communicate about the PSSM

Add the PSSM to quality and safety committee, executive leadership, Board, and medical executive committee agendas to begin informing.

02

Take the self-assessment

At a minimum within key patient safety committee(s); however, consider distributing and collecting results from various perspectives for a true “360 view” of perspectives.

03

Establish action plans re: PSSM

Plan and develop a timeline surrounding each domain and attestation item. Consider where documentation can occur on an ongoing basis.

04

Join or re-engage with learning networks

Inventory PSO, national collaborative, and hospital association engagement(s) that could comply with this measure.

05

Adjust BOD agendas to include PSSM progress updates

It’s never too early to engage the Board and get them thinking about the PSSM and to seeing more safety content on the standing agenda.

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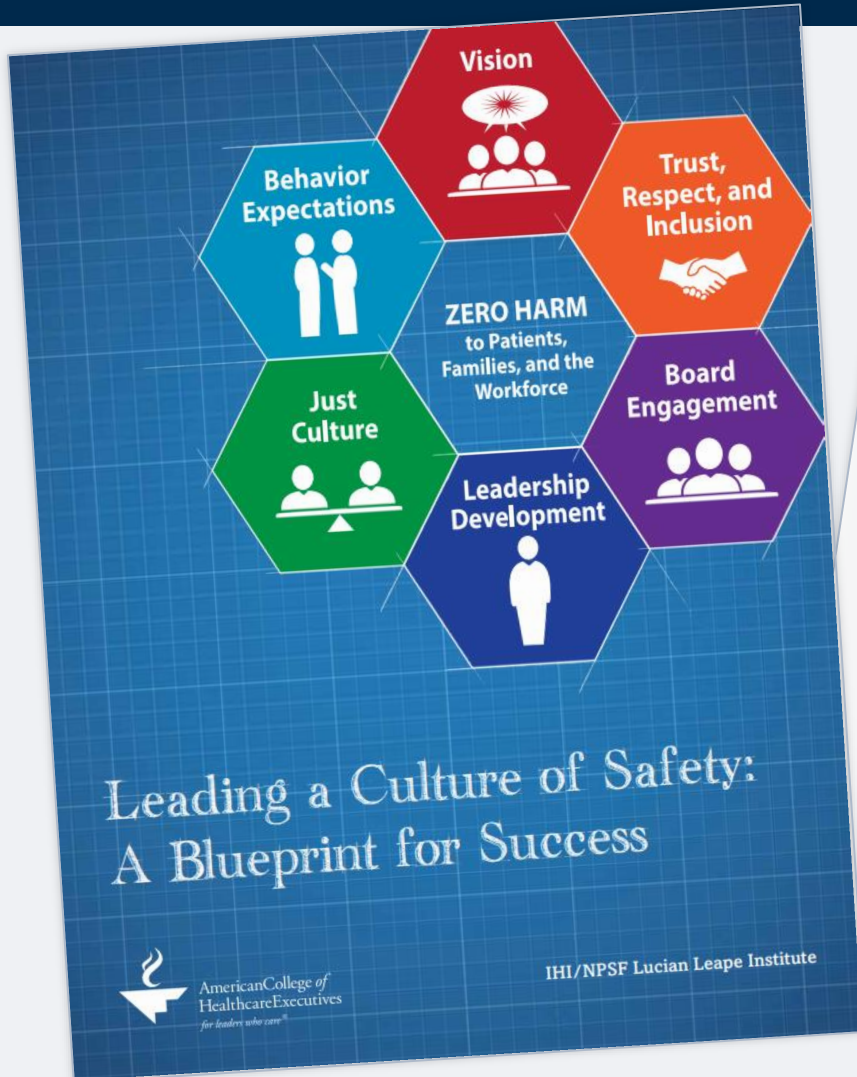
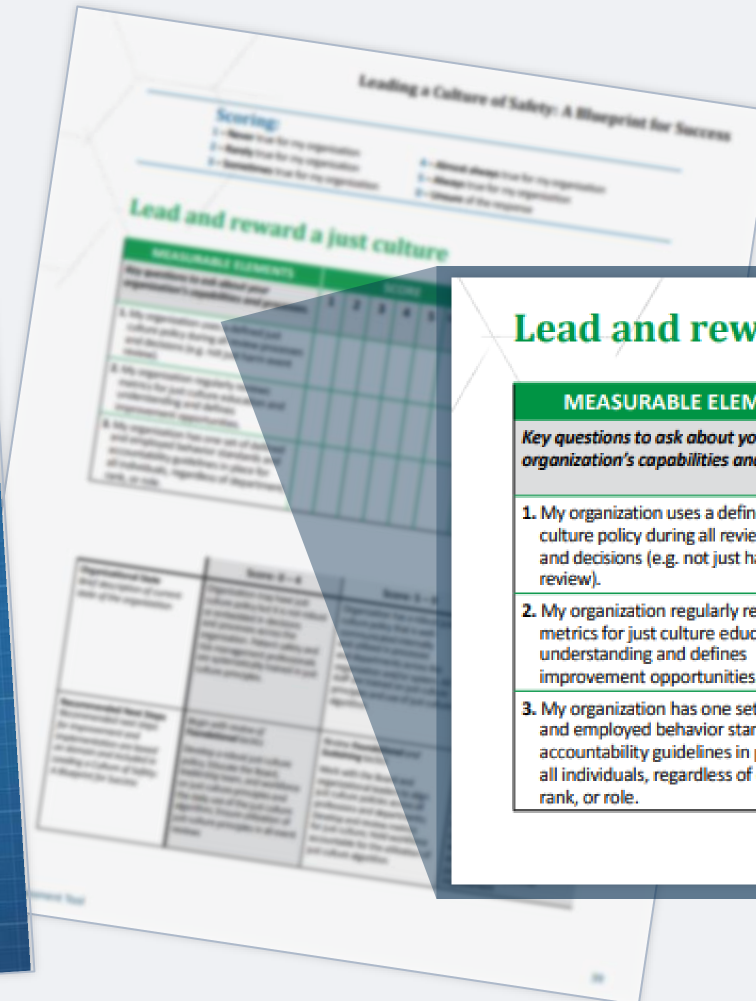
Resources to help you





Lead and reward a just culture

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
Key questions to ask about your organization's capabilities and processes.	1	2	3	4	5	Unsure 0	*Please provide a brief description of why you chose this score, considering all parts of each question.*
1. My organization uses a defined just culture policy during all review processes and decisions (e.g. not just harm event review).							
2. My organization regularly reviews metrics for just culture education and understanding and defines improvement opportunities.							
3. My organization has one set of defined and employed behavior standards and accountability guidelines in place for all individuals, regardless of department, rank, or role.							

Total Score = ______

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Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization (cont):** ✓ Recognize and reward reporting with the goal of reducing and eventually eliminating anonymous reporting ✓ Provide education and training on diversity and inclusion at every level of the organization ✓ Track employee engagement and turnover as a metric to evaluate trust, inclusion, and respect ✓ Include care disparity metrics on regularly reviewed patient safety dashboards ✓ Translate tools and resources for both patients and the workforce into a variety of languages, keeping in mind cultural context and linguistic idiosyncrasies ✓ Adopt communication and resolution/reconciliation programs for patients and families after events of preventable harm ✓ Establish patient and family advisory councils	**To engage clinical leaders:** ✓ Provide training for physicians, nurses, and other clinical leaders around patient engagement and communication ✓ Provide cultural competency training for all clinical leaders that is relevant to the patient populations they serve **To engage patients and families:** ✓ Encourage and enable patients and families to speak up if they notice a risk to safety ✓ Ensure that crisis plans address how to communicate with patients and families in the event of an error, regardless of degree of harm ✓ Commit to shared decision making and consider patient preferences in all treatment plans ✓ Engage patients and families in creating and disseminating patient compacts that include what patients can expect from the organization, their care providers, and the workforce
Assessing Execution *List of questions that should be asked to further assess and measure progress*	YES / NO ☐ ☐ Are all clinicians and workforce members provided with training in communicating with patients, including disclosure and apology? ☐ ☐ Are measures of respect included in all performance assessment tools? ☐ ☐ Is a formal program for respect and trust in place and evaluated regularly? ☐ ☐ Is there systematic training on diversity and inclusion for both the clinical and non-clinical workforce? ☐ ☐ Do the Board and leadership team regularly create and evaluate improvement plans for addressing disparities in patient care?	

✓ Foundational criteria

✓ **Sustaining** criteria

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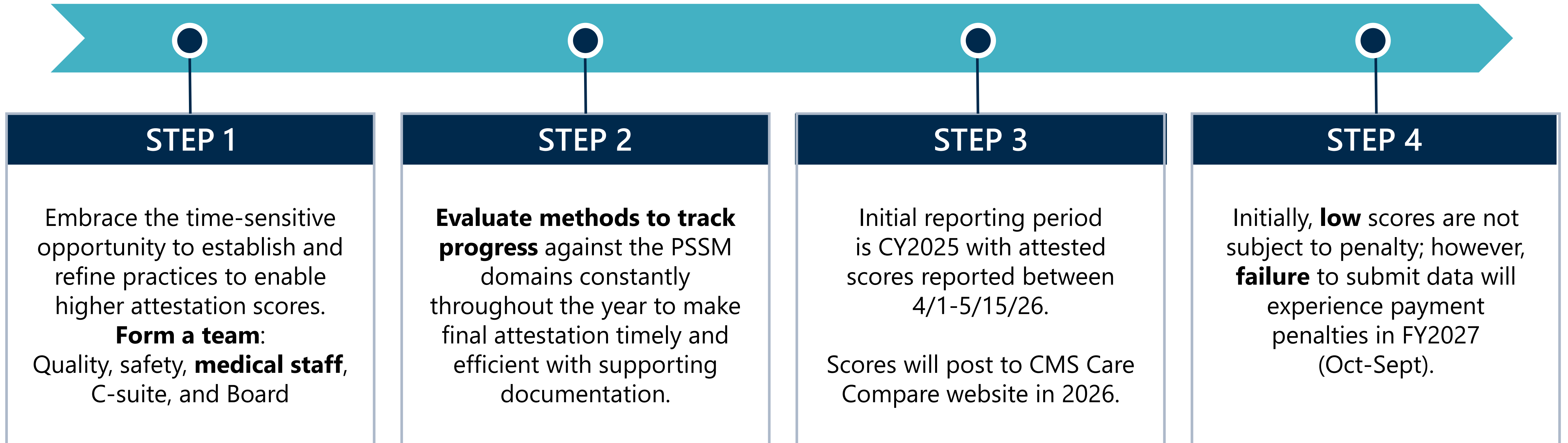
Next steps & important dates



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The ins- and outs of attesting

- Submitting in the affirmative (i.e. checkboxes)
- Multiple hospitals reporting under the same CCN?
  - Selecting “yes” means you are able to attest “yes” for ALL sites
- 25 total elements across 5 domains, each domain representing one point towards a total score of 0-5
  - Sorry, no partial credit within a domain – all practices must be met to achieve the domain point
- Attestations will be reported through NHSN
  - Results visible on the Care Compare website

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Resources

DOMAIN 1

- Blueprint: Leading for Safety | American College of Healthcare Executives
- National Action Plan to Advance Patient Safety | IHI
- Governance of Quality Assessment Online Tool | IHI

DOMAIN 2

- TeamSTEPPS 3.0 | AHRQ
- Workforce and Workplace Violence Prevention | AHA
- Healthy Work Design and Well-Being Program | CDC

DOMAIN 3

- Survey on Patient Safety (SOPS) Hospital Survey | AHRQ
- Improving Patient Safety in Hospitals: A Resource List for Users of the AHRQ Hospital Survey Culture | AHRQ
- RCA2: Improving Root Cause Analyses and Actions to Prevent Harm | IHI

DOMAIN 4

- Patient Safety Organizations | AHRQ
- Communication and Optimal Resolution (CANDOR) | AHRQ
- Visual Management Board Component Kit | AHRQ

DOMAIN 5

- Patient and Family Advisory Councils: Resources for the Field | AHA
- Advancing Effective Communication: A Road Map for Hospitals | The Joint Commission

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Questions/discussion

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Thank *you*

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