Institute *for* Healthcare Improvement

December 16, 2023

We write on behalf of the Institute for Healthcare Improvement (IHI) and the IHI's Lucian Leape Institute (LLI) to convey our enthusiastic support of the Patient Safety Structural Measure (PSSM) (#MUC2023-188) on the CMS list of Measures Under Consideration.

As we near the twenty-fifth anniversary of the publication of *To Err Is Human: Building a Safer Health System*, it is apparent that despite bright spots of progress in reducing certain harms, progress across healthcare has proven to be variable, incremental versus transformational, and fragile in the face of stressors such as the COVID-19 pandemic. Given the realities of high patient demand and increasing complexity and acuity, workforce shortages and an increasingly contingent workforce, heightened rates of burnout, moral injury, and compassion fatigue, and work environments with unhealthy cultures and increasing rates of physical and nonphysical violence, the time to act is now.

Safety in any complex, high-risk industry such as healthcare requires recognition that safety is a dynamic system property and requires enduring attention to the sociotechnical systems in which work is done. Yet common approaches to safety have often focused on reacting to preventable harms, often through a disproportionate focus on optimizing human performance while less attention has focused on improving the systems and environments in which humans work. For this reason, the IHI convened the twenty-seven member associations, organizations, and patient and family leaders of the National Steering Committee for Patient Safety to collaborate on creating *Safer Together: A National Action Plan to Advance Patient Safety*. *Safer Together* provides a clear blueprint for leaders to assess and focus their opportunities for improvement across foundational areas of culture, leadership and governance, patient and family engagement, workforce safety and wellbeing, and the learning system, including key leadership practices and behaviors that are necessary for total systems safety. To date, many organizations that have used the *Safer Together Organizational Assessment Tool* have identified both bright spots and enormous opportunities for improvement in these areas. The recently released recommendations of the Subcommittee of the National Advisory Council state the aim to ensure that all healthcare systems strengthen their foundations in patient and workforce safety through assessing and addressing the four foundational areas outlined in the National Action Plan. While the Plan provides the blueprint for healthcare leaders to shape the structures and processes for realizing safety, to date, there is no incentive or

obligation for leaders to do so, and no public insight into whether or how well hospitals are doing so.

The PSSM is well aligned with the above and provides a critical pathway and framework for doing so by recognizing hospitals and health systems that are exemplars for their enduring commitment, leadership, and action on patient safety. The PSSM Domain criteria ask hospital leaders to attest to the structures and culture that patients and the health care workforce expect all hospitals to create and sustain. The PSSM aligns with the *Safer Together* National Action Plan, scientific evidence from existing patient safety literature, the CMS National Quality Strategy, and the September 2023 Report to the President: A Transformational Effort on Patient Safety, issued by the President's Council of Advisors on Science and Technology. For these reasons, the IHI and LLI support the PSSM, and we offer additional suggestions for your consideration:

1. **Domain 1:** We suggest adding language to Statement 3 to ensure that the resources are equitably available to all members of the health care team, including the contingent workforce, and across all settings within the hospital to ensure the same standard of care and practice. *Rationale: The emphasis on "equitable availability" ensures that leaders apply the same standard of care and practice for all staff, contingent workers, and locations of care within the hospital.*
2. **Domain 2:** We suggest incorporating patient "and workforce safety" in the Domain description and in Statements 1 and 2, as well as the inclusion of contingent staff into Statement 4. It may be beneficial to provide an explicit operational definition of harm to include both physical and nonphysical harms in Statement 5. *Rationale: Workforce and patient safety are inextricably linked. The incorporation of "contingent staff (or workforce)" sets the leadership expectation that all members of the workforce are aware of, educated on, and have the same standard of expectations as employed staff and permanent workers. Adding an operational definition or language that notes both physical and nonphysical harm reinforces is consistent with what matters to patients, families, and the workforce.*
3. **Domain 3:** We suggest that hospitals attest both to their use of adverse event analysis tools and that they have a related process to share findings and promote learning for improvement throughout the organization in Statement 2. For the first sub-bullet of Statement 4 we encourage the inclusion of unit safety huddles at all shift changes in addition to daily tiered and escalating huddles. For the final sub-bullet of Statement 4 we encourage explicit reference to "safety risks and hazards" in addition to "precursor

events”. *Rationale: While hospitals conduct adverse event reviews, there is often a shortfall in whether and how learnings from the process are communicated and shared more widely. The addition of unit shift huddles ensures that the foundational safety practice is consistently utilized in a manner that benefits patients, families, and the workforce. Since “precursor events” is not a standardized term that is understood across the healthcare community, the addition of “safety risks and hazards” makes more explicit the importance of contributing factors to preventable harm.*

4. **Domain 4:** We suggest amending the language to read “…there must exist a culture that promotes event reporting **and explicit expectations** for reporting without fear or hesitation…” (with the addition of “and explicit expectations” in the description of the domain). We encourage the addition of “workforce safety” to Statements 1 and 3. Rationale: *The addition of “explicit expectations” fosters assurance that reporting is not only safe, but a standard and expected behavior to advance safety.*
5. **Domain 5:** We suggest including language to ensure that the PFAC *meets regularly* in Statement 1. We encourage amending Statement 3 to read “Patients *and whomever they authorize* have comprehensive *and timely* access to and are encouraged to view their own medical records and clinician notes via patient portals and other options, and *the hospital provides technical assistance for access as well as* support to help patients interpret information that is culturally- and linguistically appropriate as well as submit comments for potential correction to their record. *Rationale: Many PFACs still do not meet regularly. Patients and their authorized delegates to medical records often encounter barriers to access their records when hospitalized, often when most needed. Timely assistance to ensure access is not consistently available in hospitals.*

For the reasons noted above, the IHI and LLI stand in alliance and full support for the PSSM.

Thank you for the opportunity to make this public comment.

Respectfully submitted on behalf of the Institute for Healthcare Improvement and the IHI Lucian Leape Institute,

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