I am writing in personal support of the Patient Safety Structural Measure (#MUC2023-188) in the CMS Measures Under Consideration.

Background:

My work in patient safety was initiated by the loss of my nine-year-old daughter, Alyssa, to preventable medical errors. The first error was unintentional, but it was the subsequent harms that were intentional. Those harms ranged from lack of transparency, honesty, and truth telling after the event to creating a just and learning culture. Silence was the prevailing sound reverberating from the organization. As a result of my experience, I have harnessed my grief, passion, and energy in fighting for accountability and transparency in healthcare, incorporating patients and families into the improvement efforts, and learning from the mistakes to avoid harming others in the future.

I serve as a Co-Founder of Patients for Patient Safety, which represents patients committed to making our healthcare systems safer, reducing preventable harm, and advancing transparency towards learning when harm occurs. I was on the Governing Board of the Collaborative for Accountability and Improvement, I am currently on the on Solutions for Patient Safety (SPS) Board of Directors, a pediatric safety learning network, Leapfrog Patient and Family Caregiver Expert Panel, and the Diagnostic Excellence Committee at NQF. Finally, I served on the PSSM technical expert panel (TEP).

The Patient Safety Structural Metric:

The Patient Safety Structural Metric (PSSM) provides much needed guidance as to the structural ways that health systems can deliver safer care and aligns in its domains with other national guidance such as the AHRQ National Action Plan.

I support the PSSM for the following reasons:

1) It demands accountability and transparency after harm which is a moral and ethical right all patients and families deserve.
2) Prioritizes involving patients and families in co-production and improvement work.
3) Learning occurs through event reviews and improvement efforts and dissemination is encouraged through large-scale learning network(s).
4) Governing boards are educated on patient safety and held accountable.

While I am supportive of all five domains, I would like to specifically address Domain 4: Accountability and Transparency. Since my daughter died, I have dedicated much of my time to improving accountability and transparency. I was part of developing AHRQ's Communication and Optimal Resolution (CANDOR) toolkit, written articles discussing transparency, and have spoken nationally and internationally on this topic. Patients and families deserve transparent and honest conversations after harm events. Requiring organizations to implement and embed evidence-based communication and resolution programs benefits all parties. Having a designed structure from reporting of harms, learning from event reviews, communicating transparently with patients, families, and staff, providing financial and emotional support for patients and families, and caring for healthcare providers, and the organization after medical errors.

Communicating after harm events should be *the* standard of care and not default to a deny and defend strategy.

The Patient Safety Structural Measure elevates patient safety as a priority in healthcare and encourages positive actions and accountability to make care safer for organizations, healthcare providers, and patients and families. It is a positive step in the right direction towards safer care. Thank you for considering my public comment in support of the Patient Safety Structural Measure.

Respectfully,

Carole Hemmelgarn