WHITE PAPER

Patient Safety Structural Measure (PSSM): When the Score Goes Public.

Reading your Patient Safety Structural Measure result and what you can still change before December 31, 2026

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A PLAN FOR THE 2027 WINDOW

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> In the coming weeks, CMS is expected to post the first public Patient Safety Structural Measure (PSSM) scores for every hospital in the Inpatient Quality Reporting program on Care Compare, in the same place where patients and boards see the star rating. This spring, roughly 3,000 hospitals participating in the Hospital Inpatient Quality Reporting (IQR) and PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) programs were required to attest to the measure for the first time. This fall, each of those attestations will become a score that informs public perceptions of quality and supports competitive comparisons.

Additionally, and even more importantly, the CY 2026 performance year ends on December 31. Anything not in place by then cannot be attested next April, which means the score a hospital will carry through fall 2027 is being decided now, in the last quarter of this year.

This paper explains how to read the number that will be posted this fall, what it can and cannot say about a hospital, and what can still be changed before December 31. Along the way, it recaps the measure's mechanics and summarizes what CMS's first-cycle clarifications reveal about where hospitals struggle.

Reading the Number

Until now, the PSSM has been an internal exercise. Public reporting turns it into a reputational signal. Boards, referring physicians, employers, payers, journalists, and prospective patients will be able to see a hospital's score beside its star rating, and they could compare it to the hospital across town. A few key highlights on how to read the measure score correctly.

- **It displays only the total.** Domain-level results are not posted. The public will not know whether a 3 reflects a missing Patient Safety Organization relationship or a Patient and Family Advisory Council without board representation. They will just see a 3 next to a competitor's 5.
- **Scoring is all-or-nothing by domain.** A hospital earns one point for a domain only if it attests “yes” to all five statements in that domain; there is no partial credit. A hospital can meet 23 of 25 statements and post a score of 3, indistinguishable from a hospital that meets 15. The table below shows how small gaps translate into public scores.

Statements met	Where the gaps fall	Score posted on Care Compare
25 of 25	None	5
24 of 25	One statement in one domain	4
23 of 25	One statement in each of two domains	3
23 of 25	Two statements in the same domain	4
20 of 25	One statement in each domain	0

- **Hospitals sharing a CMS Certification Number take the lowest score.** When multiple hospitals report under one CCN, the lowest facility score is the score that is published. One unprepared campus sets the public number for all of them.

A low score reflects structure and documentation, not outcomes, and a gap of one statement can cost a full point. For strategy: domain concentration matters. A hospital deciding where to invest limited improvement capacity before December 31 should first look at domains where it is one statement away from a point, not the domain with the most gaps. There are also governance implications as well. For example, the board must be notified of serious safety events within three business days (D1-E) and devote at least 20% of its agenda to safety (D1-D). The board itself is part of the measure. Trustees should expect to be asked how the hospital scored and to have seen the attestation before submission.

What the Score Can and Cannot Tell You

A straightforward interpretation of the PSSM is that it is a self-reported structural assessment. CMS has not implemented any audit or verification process for these attestations, and a low score does not result in any direct payment penalties. The only safeguard against misreporting is the hospital's own compliance and integrity. Safety science has a name for the gap this invites: the delta between work-as-imagined and work-as-done. A hospital can attest in good faith to structures that exist on paper and underperform in practice, a just-culture policy nobody applies, a huddle that happens but changes nothing. If the first national distribution bands near a score of 5, a plausible outcome for an unaudited attestation measure, then a score of 5 will distinguish little, and the meaningful information will lie in the scores below it.

None of this is a reason to dismiss the measure. It is the reason evidence matters. An attestation is a formal representation made to CMS in connection with a payment program. The hospital that can produce the evidence behind every “yes” to its board, to a surveyor, or to anyone who later questions the attestation is in a different position from the one that clicked through the form.

The Measure in Brief

The PSSM is an attestation-based structural measure. Rather than counting outcomes such as infections or falls, it asks whether a hospital has built the governance, culture, and learning systems that prevent harm in the first place. It was adopted in the FY 2025 Inpatient Prospective Payment System (IPPS) final rule (August 2024).

It is organized into five domains:

1. Leadership Commitment to Eliminating Preventable Harm
2. Strategic Planning & Organizational Policy
3. Culture of Safety & Learning Health System
4. Accountability & Transparency
5. Patient & Family Engagement

Each domain contains five attestation statements, 25 in total, labeled D1-A through D5-E on the NHSN attestation form. The facility score is the sum of the domain scores, from 0 to 5. Several operational details matter more than they first appear:

- **Submission is through NHSN, not HQR.** Hospitals attest on the CDC's National Healthcare Safety Network (Form 57.133) at the NHSN OrgID level. A health-system-level attestation does not satisfy the requirement.
- **Attestation covers the prior calendar year, any time during the year.** A practice that began in June still supports a “yes” for that year.
- **It is pay-for-reporting.** A low score carries no direct payment penalty. However, failing to submit a complete attestation could put the hospital's IQR annual payment update at risk.
- Critical access hospitals may attest voluntarily but are not required to.

Key Milestones and Dates

Dates reflect CMS and CDC guidance as of September 2026. Confirm against the Hospital IQR Program deadlines calendar on QualityNet for the latest.

Milestone	Date
First public reporting of scores on Care Compare and the Provider Data Catalog (CY 2025 data)	Fall 2026 (expected with the October 2026 Care Compare refresh)
End of the CY 2026 performance period — last day a practice can begin and still support an April 2027 attestation	December 31, 2026
Second attestation window (CY 2026 data) for FY 2028	April 1 – May 17, 2027
Public reporting of CY 2026 scores	Fall 2027
FY 2025 IPPS final rule adopts the PSSM	August 2024
First performance period (CY 2025)	January 1 – December 31, 2025
First attestation window (CY 2025 data) in NHSN	April 1 – May 18, 2026
FY 2027 payment determination takes effect	October 1, 2026
Standing annual cycle	Perform Jan–Dec; attest Apr 1–May 15 (moved to the next business day when the 15th falls on a Friday or weekend); public reporting the following fall

What CMS's Clarifications Reveal About Where Hospitals Struggle

The CY 2025 attestation was hospitals' first attempt to hold themselves to the measure. No national data on where hospitals fell short has been published. What exists is indirect evidence: CMS clarifications, questions hospitals raised through the QualityNet Q&A tool, and client conversations we have had. Read together, a small number of statements appear to have accounted for most of the difficulty.

- **Domain 5 is easy to underbuild.** Many hospitals have a PFAC oriented to amenities and patient experience rather than safety governance. D5-A requires PFAC representation at board meetings and consultation on safety goals and metrics; D5-B requires a membership representative of the patient population. Hospitals that are part of systems also learned that a system-level PFAC does not count. Each hospital needs its own.

- **Survey cadence can trip otherwise strong culture programs (D3-A).** The statement allows an annual validated survey or a biennial survey with pulse surveys on target units in the off year. Hospitals on a two-year cycle that skipped the off-year pulse survey could not attest. CMS has also clarified that safety rounds do not count as a pulse survey and that the hospital itself determines whether its instrument is validated.
- **Board agenda time is hard to evidence (D1-D).** Boards rarely measure what share of their agenda is devoted to safety. Meeting the 20% threshold is often less of a problem than proving it.
- **Serious safety event notification often lacks a formal protocol (D1-E).** In practice, many hospitals inform executives quickly but have no written process for notifying designated board members within three business days. CMS clarified that the full investigation need not be complete within that window and that notifying the designated board members, not the full board, is sufficient.
- **The seven high-reliability practices are more prescriptive than the headline suggests (D3-D).** For any practice a hospital counts toward its required four, the cadences bind: huddles must run at least five days a week, including one weekend day; leader rounding must be monthly on all units, with C-suite rounding at least quarterly; the safety data infrastructure must reach the C-suite monthly and the board at every regular meeting. Hospitals that assume "we do huddles" is enough often discover gaps in cadence and follow-up.
- **Communication and resolution programs often exist, but measurement does not (D4-E).** Hospitals with CANDOR-style programs often have no standard measures of program performance reported to the board quarterly, which is separate from having the program itself.
- **The PSO requirement was binary (D4-B).** Only hospitals working with an AHRQ-listed Patient Safety Organization can attest "yes." Hospitals that had let a PSO membership lapse, or that used a non-listed vendor for event analysis, lost the entire Accountability & Transparency point.

The conclusion is that PSSM rewards documented, reliable structure, not good intentions or strong outcomes. Hospitals with excellent safety records could still score below 5 if a single structural element was informal, lapsed, or undocumented. CMS has not established an audit or validation process, but assembling evidence is the surest way to attest accurately, and it prepares the organization for the day a board member, surveyor, or journalist asks.

What to do now: A Plan from October 1 to the 2027 Window

> The best response to PSSM is not to game the measure.

As attestation covers the prior calendar year and a practice begun at any point during the year supports a “yes,” some gaps remain fixable this quarter: executing a PSO agreement, writing the notification protocol, chartering a hospital-level PFAC, administering an off-year pulse survey. Others are cadence-based: huddles five days a week, monthly rounding, and the 20% agenda threshold across the year's meetings. A practice launched in November is a thin basis for a “yes.” CMS has not specified minimum durations, so the conservative reading is that cadence practices need to be operating, not merely started, and each hospital must assess this accordingly.

Anything not in place by December 31, 2026, cannot be attested in April 2027. With roughly a quarter of the performance year remaining, the work divides naturally into three phases.

October 1 – December 31, 2026: close the gaps that can still count

- Run an internal mock attestation against all 25 statements. Score each statement yes, no, or uncertain, and resolve every “uncertain” with the CMS Attestation Guide and FAQs.
- Prioritize domains that are one statement away from a point. A single action, such as adding a PFAC member to the next board meeting or scheduling a pulse survey on target units, can be worth a full point.
- If the hospital is on a biennial culture survey cycle and 2026 is an off year, administer the pulse survey before year-end.
- Confirm the PSO agreement is active and that patient safety work product has been shared during 2026.
- Adopt or update the written serious safety event notification protocol and, if needed, the board agenda template that makes safety time measurable.
- Brief the board on the fall 2026 public score and the plan for CY 2026.

January – March 2027: assemble and verify evidence

- Build a single attestation evidence file organized by statement, with an owner named for each of the 25.
- Confirm NHSN access (SAMS credentials, Facility Administrator and user rights) for the people who will attest, and confirm the correct OrgID for each hospital, particularly where hospitals share a CCN.

- Review the September 2025 CMS Specifications and Attestation Guide and the current NHSN Protocol for any updates, and monitor the FY 2028 IPPS proposed rule (expected in April 2027) for any proposed changes to the measure. Obtain executive and, where appropriate, board sign-off on the draft attestation.

April 1 – May 17, 2027: attest, verify, and communicate

- Submit on NHSN Form 57.133 for each OrgID. Attest “yes” or “no” to all 25 statements; an incomplete form does not satisfy the reporting requirement.
- Run the NHSN Line List – PSSM Domain Report and Facility Score Report to confirm the recorded responses and scores match what was intended, and correct them before the deadline.
- Where hospitals share a CCN, compare facility scores and understand which one will be published.
- Prepare internal and, if desired, external communication about the score in advance of fall 2027 public reporting.

Looking Ahead

The measure itself has been stable. The FY 2026 and FY 2027 IPPS final rules left the domains and statements unchanged, and CMS's September 2025 specification refresh clarified rather than altered them. Three developments are worth watching:

- **The first public scores.** The fall 2026 release will establish the national baseline and, inevitably, the first rankings. Hospitals should decide before publication how they will talk about their score.
- **Future rulemaking.** CMS has signaled a broader shift toward outcome measures and electronic clinical quality measures. Whether the PSSM eventually acquires domain-level public reporting, an audit or validation component, or a link to payment beyond pay-for-reporting will be decided in future IPPS rules, beginning with the FY 2028 proposed rule, expected in spring 2027.
- **Convergence with other structural expectations.** The PSSM's requirements overlap with the Joint Commission's leadership and safety culture standards, Leapfrog's safety practices, and state reporting programs. Hospitals that build a single evidence system for all of them will find the annual attestation increasingly routine.

Conclusion

The Patient Safety Structural Measure asks a very simple question in 25 parts: has the hospital built the structures that make safe, reliable care possible? For the first time, the answer will be public and will inform public perceptions of quality and safety.

We believe the PSSM is a constructive step for the American healthcare system because it rewards structure over luck. We urge leaders to use the remaining months of 2026 to close the gaps that still matter, gather the evidence behind every “yes,” and continue investing in the culture, learning, and engagement systems that consistently deliver safe, high-quality, and equitable care.

Resources

- CMS, Patient Safety Structural Measure Specifications and Attestation Guide (September 2025), QualityNet, Hospital IQR Program measures page.
- CMS, Patient Safety Structural Measure Frequently Asked Questions (April 2026), Quality Reporting Center.
- CDC/NHSN, Patient Safety Structural Measure Protocol (January 2026), Attestation Form 57.133, and PSSM Analysis Quick Reference Guide (March 2026).
- CMS, FY 2025 IPPS/LTCH PPS Final Rule (Federal Register, August 28, 2024).
- AHRQ, Communication and Optimal Resolution (CANDOR) Toolkit; Surveys on Patient Safety Culture; directory of listed Patient Safety Organizations.
- National Steering Committee for Patient Safety, Safer Together: A National Action Plan to Advance Patient Safety (IHI, 2020).

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