Advancing Health Care Safety for All

Patient safety is a fundamental principle of health care and a critical component of high-quality, equitable care. Despite advancements in medical science and technology, patient safety remains a significant concern.

As the largest payer of health care services in the United States, serving over <u>160</u> <u>million</u> Americans, the Centers for Medicare & Medicaid Services (CMS) is committed to reducing patient harm and promoting a culture of safety for patient



committed to reducing patient harm and promoting a culture of safety for patients nationwide. In alignment with the **CMS National Quality Strategy**, this three-point safety plan outlines CMS's path to promote zero preventable harm. Patient safety is multifaceted and requires integrated and coordinated systemic actions to make a difference. Improving patient safety is fundamental to addressing disparities and inequities in health care for all.

CMS's Path to Promote Zero Harm for All



Promote Transparency



Advance Safety Culture
Through Partnership



Incentivize Zero Harm

Provide individuals, families, and caregivers with more safety information, in a format they can understand, to make informed decisions about where they seek care. Give providers the necessary feedback and data to eliminate preventable harm.

Collaborate and actively engage patients, providers, health care organizations, federal partners, states, and other partners to empower patient voices, implement systemic changes, and eliminate disparities in patient safety.

Drive health care leadership and governing bodies to make safety a priority and eliminate preventable harm.

Promote Transparency

Making more informed health care decisions requires patients to have timely, accessible, and understandable information about potential harm, near misses, and other critical safety issues. Transparency also helps providers identify patterns or systemic issues in care processes that may lead to patient harm and can raise awareness of safety events and how they are handled. Reported data can be used to implement changes to prevent future errors, drive quality improvement, build trust, and promote accountability to improve safety within our health care system.



Advance Safety Culture Through Partnership

Working together with many different partners—health care organizations, providers, patients, caregivers, community groups, organizational safety experts, states and others—to standardize and share effective safety practices helps achieve measurable improvement in patient safety, create a culture focused on quality improvement, and empower the patient voice. Collaboration can drive the systemic changes needed to remediate root causes of safety issues and disparities in quality and safety.

Incentivize Zero Harm

Achieving zero preventable harm begins with setting expectations of reduced harm and furthering efforts to improve safety practices. Incentivizing zero harm means taking a proactive approach—by identifying opportunities to reform payment and coverage policies to discourage payment for preventable harm—to prevent harm to individuals across their care journey.

CMS Key Actions to Advance Safety for All

Advance Safety Culture

- Encouraging providers through implementation of the <u>Patient Safety Structural Measure</u> to ensure patients have access to their own medical records and clinician notes with an opportunity to suggest correction.
- Incorporating a safety element (e.g., measure, methodology refinement) across all care settings through quality reporting and <u>value-based</u> <u>payment programs</u>.
- Convening a coalition to engage the health care sector in exploring ways to collectively reduce administrative burden and advance solutions that improve patient safety, care delivery, and workforce well-being.
- Partnering across the federal government to support more robust learning ecosystems and mechanisms for safety reporting, such as the <u>National Action Alliance for Patient and</u> <u>Workforce Safety</u>.
- Delivering direct technical assistance to improve patient safety through the <u>Quality Improvement</u> <u>Organization Program</u>.
- Promoting the integration of <u>High Reliability</u>
 <u>Organization</u> best practices into CMS quality initiatives, including a culture of safety and structured communications.

Promote Transparency

- Implementing the <u>Patient Safety Structural</u>
 <u>Measure</u> will provide individuals with information
 on whether hospitals are following best evidence based practices for safety.
- Sharing actionable performance data on safety through the <u>Care Compare tool</u>.
- Supporting more comprehensive and consistent reporting of <u>Serious Reportable Events</u>.
- Exploring a <u>higher weight for patient safety</u> in hospital <u>Star Ratings of Care Compare</u>, informed by public comment.
- Using technology and innovation to advance interoperability and drive better clinical decision making. This includes:
 - timelier access to data
 - more robust data capture
 - ability to stratify data
 - more standardized reporting of safety events

Incentivize Zero Harm

- Rewarding Excellence for Underserved
 Populations (REUP) to reward healthcare providers
 that perform well on quality measures and serve a
 high percentage of patients who are dually eligible
 for Medicare and Medicaid.
- <u>Identifying available authorities</u> to prevent, where appropriate, paying for services that result in harm.

Questions? Contact us at QualityStrategy@cms.hhs.gov

