NATIONAL QUALITY STRATEGY
Better Care. Healthy People/Healthy Communities. Affordable Care.

PRIORITIES IN FOCUS

March 2016

Making Care Safer

THE 17 PERCENT REDUCTION IN HOSPITAL-ACQUIRED CONDITIONS SAVED 87,000 LIVES AND 20 BILLION DOLLARS

THE ISSUE: MAKING CARE SAFER

Though health and health care providers continue to work toward a delivery system focused on high-quality care, hospital-acquired conditions and harmful complications acquired from ambulatory health care delivery remain common. One in seven Medicare patients, for example, are harmed during a hospital stay.[1] Each year, hospital-acquired conditions in particular remain a significant cause of morbidity and mortality for Americans and lead to lost economic output.[2,3]

In an increasingly complex health care delivery system where patient safety depends on a range of factors, successful prevention of harm hinges on the effective identification and elimination of the potential for preventable error, avoidance of blame assignation while remaining accountable to outcomes, and transformation of the culture of medicine to ensure that patients receive high-quality care. Prevention of medical errors saves lives and lowers cost—goals shared by all stakeholders across the system and a key to achieving the three aims of the National Quality Strategy.

THE NATIONAL QUALITY STRATEGY SOLUTION

The National Quality Strategy calls all stakeholders to make care safer across the health care system by focusing on three long-term goals:

- Reduce preventable hospital admissions and readmissions
- Reduce the incidence of adverse health care-associated conditions
- Reduce harm from inappropriate or unnecessary care

The Affordable Care Act focused national efforts on improving these long-term goals to make care safer for all Americans. The Partnership for Patients initiative, a public-private partnership of more than 8,400 stakeholders, set an ambitious target to achieve the above long-term goals: reducing hospital-acquired conditions by 40 percent and hospital readmissions by 20 percent over 3 years, compared to a 2010 baseline. Hospitals across the country are critical partners in this work, with over 3,700 currently participating. A key element of Partnership for Patients is the Hospital Engagement Network (HEN) system. With 17 hospital systems currently participating, HEN members work at the regional, State, and national levels to first identify solutions that have demonstrably reduced hospital-acquired conditions and then facilitate the expansion of those solutions to other hospitals and health care providers.

Partnership for Patients' efforts, combined with the Centers for Medicare & Medicaid Services (CMS) Readmissions Reduction Program, which penalizes

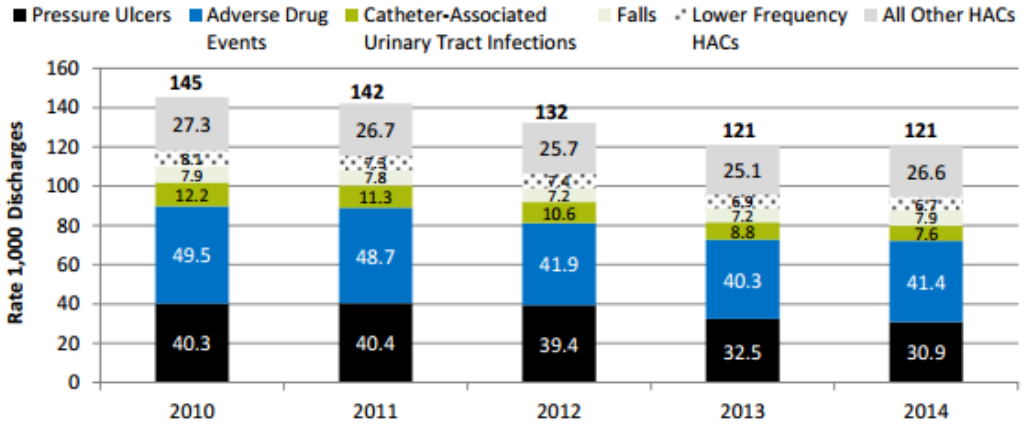
excess readmissions, have led to a reduction in all-condition Medicare readmission rates. Early results also suggest the Partnership and other efforts focused on improving patient safety have made significant progress toward reducing the incidence of hospital-acquired conditions.

WHERE WE ARE NOW: 2015 PATIENT SAFETY CHARTBOOK

The AHRQ 2015 National Healthcare Quality and Disparities Report Chartbook on Patient Safety showed an overall trend of improvement in patient safety. Among patient safety measures with trend data available from 2001–2002 through 2013, over 60 percent showed improvement over time. However, many disparities persisted. For about one-third of patient safety measures, high-income households received better care than poor households, and Whites received better care than Blacks and Asians.

The most significant improvement in patient safety reported in the 2015 Quality and Disparities Report Chartbook is the 17 percent decline observed in hospital-acquired conditions from 2010 to 2014. As shown below, the overall rate of hospital-acquired conditions declined from 145 per 1,000 hospital discharges in 2010 to 121 per 1,000 in 2013. However, it remained at 121 per 1,000 hospital discharges in 2014, with slight changes in the distribution of conditions. Even with this flattening of the decline, approximately 2.1 million harmful events were avoided from 2010–2014, saving an estimated 87,000 lives and $20 billion. Among other factors, the Partnership for Patients catalyzed this concerted effort by hospitals throughout the country to reduce harm and achieve these results.

Distribution of hospital-acquired conditions, based on national rates per 1,000 adult hospital discharges, 2010-2014



Source: Agency for Healthcare Research and Quality (AHRQ), Medicare Patient Safety Monitoring System, 2010-2014; Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2010-2013; Centers for Disease Control and Prevention, National Healthcare Safety Network, 2010-2013.

[1] Levinson, D.R. Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries. Washington, DC: U.S. Department of Health and Human Services, November, 2010. Available at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.

[2] James, J.T. A new, evidence-based estimate of patient harms associated with hospital care. Journal of Patient Safety, 2013. 9(3), 122–8. http://doi.org/10.1097/PTS.0b013e3182948a69; Andel, C., Davidow, S. L., Hollander, M., & Moreno, D. The economics of health care quality and medical errors. Journal of Health Care Finance, 2012. 39(1), 39–50. http://www.ncbi.nlm.nih.gov/pubmed/23155743.

[3] Umscheid, C.A., Mitchell, M.D., Doshi, J.A., et al. Estimating the proportion of healthcare-associated infections that are reasonably preventable and the related mortality and costs. Infection Control and Hospital Epidemiology: The Official Journal of the Society of Hospital Epidemiologists of America, 2011. 32(2), 101–114. http://doi.org/10.1086/657912.