What's New in the Patient Safety World

January 2016

HAC's Have Declined Since 2010

In our February 2015 What's New in the Patient Safety World column "17% Fewer HAC's: Progress or Propaganda?" we discussed the preliminary data from AHRQ which showed that there was a 17% reduction in hospital-acquired conditions (HAC's) in the previous 3 years, saving 50,000 lives and $12 billion (AHRQ 2014). The improvement was largely attributed to government-sponsored programs. Our "hype radar" immediately went into high gear. However, after assessing the data and some corroborative data from other sources, we conceded this was one instance where our "hype radar" was wrong and that this truly was progress.

AHRQ has now released its interim data for 2010 to 2014 (AHRQ 2015). The measured interim rate for 2014 held steady from 2013 at 121 HACs per 1,000 discharges, down from 145 in 2010. That is a 17% decline in the HAC rate over the four year period. They estimate that nearly 87,000 fewer patients died in the hospital as a result of the reduction in HACs and that approximately $19.8 billion in health care costs were saved from 2010 to 2014. The news was heralded by a press release from HHS (HHS 2015) attributing the improvement to the Accountable Care Act, CMS financial incentive and penalty programs, widespread adoption of electronic medical records, the Partnership for Patients program, and HENS (Hospital Engagement Networks), among others.

Some have noted a "positive spin" in the most recent report since, in reality, HAC's remained at the same level in 2014 that they were at in 2013. That is after the rather steep decline the previous three years. The good news is that the HAC rate for 2014 did not increase, as it might if the previous "progress" were really just a statistical fluke. But does the plateau mean we've hit a barrier? The AHRQ report admits that the HAC rate is still too high and we need to continue to do more to avoid these conditions.

Over the 4-year period the biggest reductions in HAC's percentage-wise were seen for CLABSI's (-72%), CAUTI's (-38%), and post-op venous thromboembolism (-43%). But the greatest financial savings came from reductions in pressure ulcers and adverse drug events ($6.5B of the total $7.8B savings came from just these 2 categories). And of the estimated 36,295 avoided deaths, 22,444 came from reduction in pressure ulcers.

We're not surprised at the success in reducing CLABSI's and CAUTI's given the substantial evidence-based preventive interventions that have now been widely adopted

for several years. But we are, frankly, surprised at the magnitude of the reduction (-23%) in pressure ulcers.

So, of course, we would look to see if there is other evidence corroborating this significant improvement in prevention of pressure ulcers. And, in fact, we find it in data accumulated in the PA-PSRS (Pennsylvania Patient Safety Reporting System) database and reported by the PPSA (Pennsylvania Patient Safety Authority). That report (Feil 2015) confirms a substantial reduction in hospital-acquired pressure ulcers from 2011 to 2013. Feil and Bisbee describe the Pennsylvania Hospital Engagement Network (PA-HEN) Pressure Ulcer Prevention (PUP) project that achieved a 62.7% reduction in the incidence rate of stage III and IV hospital-acquired pressure ulcers in Medicare patients. That PPSA report has links to the PUP project site and to the evidence-based pressure ulcer prevention guidelines from multiple quality and patient safety organizations. You'll find that article to be very useful.

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