AHRQ Data Show HAC Rate Continues To Decline

escrito por Ana Miranda | 10 de dezembro de 2014

Here at the Agency for Healthcare Research and Quality (AHRQ), we conduct patient safety research to investigate the ways patients are harmed, why this harm occurs, and how to prevent it.

Preliminary data released today in an AHRQ research brief show that the estimated rate of harms experienced by people who have been hospitalized declined by approximately 17 percent, saving about 50,000 lives and nearly $12 billion in health care costs, from 2010 to 2013. This represents 1.3 million fewer adverse events, such as pressure ulcers, falls, adverse drug events, and healthcare-associated infections. This continued progress in making health care safer has been supported by provisions in the Affordable Care Act.

These latest data demonstrate that hospitals and providers across the country are continuing to achieve better patient safety. These major strides are a result of strong, diverse public-private partnerships and active engagement by patients and families. One major effort is the federal Partnership for Patients (PfP) initiative. In 2011, HHS set a goal of improving patient safety through the PfP, which targets the following hospital-acquired conditions (HACs) for reductions: adverse drug events, catheter-associated urinary tract infections, central line associated blood stream infections, pressure ulcers, and surgical site infections, among others. AHRQ has helped coordinate development and use of a national measurement strategy that tracks national progress on patient safety. The results using this national measurement strategy have been referred to as the "AHRQ National Scorecard," which provides summary data on the national HAC rate.

In addition to the PfP, AHRQ continues to work with other HHS agencies including the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and others to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to make sure that the evidence is understood and used.

These unprecedented results should be celebrated. However, there is more work to do. AHRQ's patient safety program continues to advance our understanding of patient safety and has produced a variety of tools and resources to help hospitals and other providers prevent hospital-acquired conditions, such as reducing infections, pressure ulcers, and falls. The tools and resources include theComprehensive Unit-based Safety Program, the Re-Engineered Discharge Toolkit, AHRQ's teamwork training program called TeamSTEPPS®, the Guide to Patient and Family Engagement in Hospital Quality and Safety, surveys to help staff in hospitals and other health care settings evaluate and improve their patient safety culture, and more.

Since the Institute of Medicine report *To Err is Human* was released in 1999, many raised concerns that not enough was being done to improve patient safety. That changed with the passage of the Affordable Care Act and other efforts of this Administration to prioritize quality and safety improvement in health care.

Now we have data that show that these efforts are paying off and patient safety is improving on many fronts. These data are showing that almost all types of adverse events are going down and that the reduction is substantial.

The data show that 800,000 fewer adverse events happened in 2013 than would have happened if the 2010 rate hadn't changed. More remains to be done, but we should mark the progress we've seen to date because it shows that we are finally on the right

track.

Many thousands of doctors, nurses, pharmacists, and other health care professionals—and the many thousands of other people who work hard in hospitals, like the people who clean rooms after one patient leaves and another arrives—took steps to do things differently to improve the safety of their patients during the last three years. All are to be commended. And I hope that they are encouraged by our findings showing that the changes that they've made have made a difference.

Richard Kronick, Ph.D., is Director of the Agency for Healthcare Research and Quality.