National Patient Safety Efforts Save 125,000 Lives and Nearly $28 Billion in Costs

New report shows hospital-acquired conditions continue to decline—drop 21 percent and 3 milli adverse events over a five year period

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A report released by the U.S. Department of Health and Human Services (HHS) today shows that nationwide ef make health care safer are paying off. Thanks in part to provisions of the Affordable Care Act, approximately 12 fewer patients died due to hospital-acquired conditions and more than $28 billion in health care costs were save 2010 through 2015. In total, hospital patients experienced more than 3 million fewer hospital-acquired conditic 2010 through 2015, the result of a 21 percent decline in the rate of these adverse events over that period. Hosp acquired conditions are conditions that a patient develops while in the hospital being treated for something els decline in their incidence aligns with a major goal of the Affordable Care Act to improve the quality of health ca

The *National Scorecard on Rates of Hospital-Acquired Conditions* represents demonstrable progress over a five-y to improve patient safety in hospitals. These data, compiled and analyzed by the Agency for Healthcare Researc Quality (AHRQ), build on results previously achieved and reported in December 2015. Last year's data showed t fewer patients died due to hospital-acquired conditions and $20 billion in health care costs were saved from 201

"The Affordable Care Act gave us tools to build a better health care system that protects patients, improves qua makes the most of our health care dollars and those tools are generating results," said HHS Secretary Sylvia M. B "Today's report shows us hundreds of thousands of Americans have been spared from deadly hospital acquired conditions, resulting in thousands of lives saved and billions of dollars saved."

Many federal efforts supported this progress toward a safer health care system, including the Partnership for Pa initiative, a public-private partnership working to improve the quality, safety and affordability of health care. HH launched the Partnership for Patients in 2011 though the Center for Medicare & Medicaid Innovation to target set of hospital-acquired conditions for reductions through systematic quality improvement. In addition, the Cent Medicare & Medicaid Services (CMS), through a program created by the Affordable Care Act, worked with hosp networks and aligned payment incentives to bring about a shared and sustained focus on making care safer.

"These achievements demonstrate the commitment across many public and private organizations and frontline to improve the quality of care received by patients across the county," said Patrick Conway, M.D., deputy admin innovation and quality and chief medical officer at CMS. "It is important to remember that numbers like 125,00 saved or over 3 million infections and adverse events avoided represent real value for people across the nation

received high quality care and were protected from suffering a terrible outcome. It is a testament to what can b accomplished when people commit to working towards a common goal. We will continue our efforts to improv safety across the nation on behalf of the patients, families, and caregivers we serve."

"Hospitals and health systems, along with their frontline clinicians, can take great pride in this progress," said Jay D.O., American Hospital Association Chief Medical Officer and president of AHA's Health Research & Educationa "Not only have they saved lives, but they've also developed tremendous capacity to tackle safety challenges—a f that will help them get to zero incidents."

Hospital-acquired conditions include adverse drug events, catheter-associated urinary tract infections, central lin associated bloodstream infections, pressure ulcers and surgical site infections, among others. These conditions w selected as focus areas because they occur frequently and appear to be largely preventable based on existing ev

Much of the evidence on how to prevent hospital-acquired conditions was developed and tested by AHRQ. For one of the tools used most frequently by hospitals is AHRQ's Comprehensive Unit-based Safety Program (CUSP), proven method that combines improvement in safety culture, teamwork and communications with evidence-ba practices to prevent harm and make the care patients receive safer. AHRQ has worked hand-in-hand with frontl clinicians to help them use CUSP in a series of nationwide projects that have been highly effective in preventing healthcare-associated infections.

"AHRQ has been building a foundation of patient safety research for the last decade and a half at the request o Congress," said AHRQ director Andy Bindman, M.D. "Now we're seeing these investments continue to pay off in lives saved, harm avoided, and safer care delivery overall. We're gratified by the progress, and we look forward building on this work to help make patient care even safer as the work continues."

AHRQ works with its HHS colleagues, researchers, doctors, nurses, other health care professionals, and health ca across the country to create new knowledge about how to improve care and make it safer, in areas such as prev healthcare-associated infections, combating antibiotic resistance, and reducing diagnostic error. As part of that AHRQ has developed a variety of methods, tools, and resources to help hospitals and other providers prevent h acquired conditions, such as infections, pressure ulcers, and falls.

AHRQ also developed the measurement strategy for the *National Scorecard* as part of the Partnership for Patier initiative. Researchers at AHRQ used national data systems to analyze the incidence of 28 avoidable hospital-acc conditions that occurred from 2010 to the first three quarters of 2015 and compared them to baseline estimate: and excess health care costs for 2010.

HHS is committed to working with partners to capitalize on this success in improving patient safety and reducin care costs while providing the best, safest possible care to patients.

View these data highlights as an infographic.

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