The National Quality Strategy (NQS) of the Agency for Healthcare Research and Quality (AHRQ) is working to make care safer, across the healthcare system. Toward that end, they have established three goals:

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

AHRQ’s Partnership for Patients (PFP) initiative is a public-private partnership of more than 8,400 stakeholders. It has set as its target:

- Achieving the goals listed above
- Reducing hospital-acquired conditions by 40%
- Reducing hospital readmissions by 20%, vs. a 2010 baseline.

More than 3,700 hospitals are now participating in this initiative.
Some overall results

PFP’s efforts, combined with the Centers for Medicare & Medicaid Services (CMS) Readmissions Reduction Program, have led to lower all-condition Medicare readmission rates.

Also, early results suggest the PFP and other efforts focused on improving patient safety have made significant progress toward reducing the incidence of hospital-acquired conditions.

Specifics: hospital-acquired conditions

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, more than 60% showed improvement over time.

The most significant improvement in patient safety reported in the 2015 Quality and Disparities Report Chartbook is the 17% decline observed in hospital-acquired conditions (HACs) from 2010 to 2014. As shown in the figure 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.

But even with this flattening of the decline, though, approximately 2.1 million harmful events were avoided from 2010–2014, saving an estimated 87,000 lives and $20 billion.

Adverse drug events (41.4 per 1,000 hospital discharges) accounted for 34.2% of total HACs and pressure ulcers (30.9 per 1,000 hospital discharges) accounted for 25.5% of the total. Among the most frequent HACs, between 2010 and 2014, the rate of pressure ulcers decreased the most, from 40.3 per 1,000 discharges (more than 1.3 million events) to 30.9 per 1,000 discharges (about 1 million events).

The catheter-associated urinary tract infection rate decreased from 12.2 to 7.6 per 1,000 discharges (400,000 and 250,000 events, respectively). Among the less frequent HACs, central line–associated bloodstream infections had the greatest percentage decrease in rate (67%) between 2010 and 2014. The rates of these HACs also decreased by the percentages indicated in parentheses: venous thromboembolism (44%), surgical site infections (17%), and obstetric events (4%) also decreased.

Between 2006–2008 (combined) and 2013, there was a 46% decrease in central line associated bloodstream infection (CLABSI). Here, the chartbook breaks down the data according to type of hospital: from 2006-2008 (combined) to 2013, rates of CLABSIs in hospitals decreased 53.8% among adult medical ICU patients in hospitals with major teaching programs, 47.6% among adult medical/surgical ICU patients in hospitals with major teaching programs, 42.1% among adult medical ICU patients in all other hospitals, and 46.7% among adult medical/surgical ICU patients in all other hospitals.

The chartbook also provides references to toolkits that practitioners can use to improve rates of (to cite one example) catheter-associated urinary tract infections (CAUTIs). Here is the summary on the toolkit for CAUTIs:

- **Purpose:** To help hospitals prevent and improve safety culture
- **Method:** Implementing evidence-based, practical resources and concepts from the Comprehensive Unit-based Safety Program
- **Intended User:** Hospital facilities
- **Available Tools:** Guides, checklists, webinars, learning modules, data interpretation guides.

Possible measures for effectiveness of what is done include:

- Number of symptomatic CAUTIs attributable to each unit by month
- Days since last CAUTI.


**Editor’s note:** The chartbook also includes additional data of potential interest for MPL, including trend data on the National Practitioner Data Bank and trend information (both national and by state) on the increase in number of Patient Safety Organizations.