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ON

PATIENT SAFETY: U.S. EFFORTS TO REDUCE HEALTHCARE-ASSOCIATED INFECTIONS AND PREVENTABLE HOSPITAL DEATHS

BEFORE THE

U.S. SENATE HEALTH, EDUCATION, LABOR & PENSIONS COMMITTEE

U.S. Senate Health, Education, Labor & Pensions Committee

Patient Safety: U.S. Efforts to Reduce Healthcare-Associated Infections and Preventable Hospital Deaths

September 24, 2013

Good morning, Chairman Harkin, Ranking Member Alexander, and members of the Senate Health, Education, Labor & Pensions Committee. Thank you for holding this very important and timely hearing and thank you for the opportunity to speak about the issues related to patient safety and the vital effort under way to reduce the number of healthcare-associated infections and preventable hospital deaths each year.

This is a major problem that is imminently addressable. Despite this fact, healthcare-associated infections and other patient safety hazards persist in causing needless deaths and suffering while increasing healthcare costs. Healthcare-associated infections are a subset of avoidable harms and the larger problem of preventable institutional deaths.

Patient Safety is an issue that has been close to my heart and my area of focus for more than 25 years. As a son of a dedicated nurse, who taught me at a very young age how important it was to help others in need, I grew up with a strong sense of commitment to use my abilities to increase patient safety. As an engineer out of college, I focused on innovation in healthcare and sought to create the best medical technologies possible to deliver hope to families and to our smallest patients —premature babies struggling for their lives. With the assistance of many dedicated people, I have been able to help improve patient care and reduce cost through development of breakthrough technologies.

I fundamentally believe technology and innovation play an important and critical role in the evolution of medicine and patient safety. We know so much less than we could about the human body and disease. When we actually understand the amazing human body and the root causes of the diseases that plague it, I project our ability to treat, if not prevent or cure, those diseases and the costs associated with this, will be much improved. While we now understand this concept, we are nowhere close to reaching this goal. Therefore, to slow down our commitment to health care innovation would be as shortsighted as failing to invest in the personal computer revolution 35 years ago. One wonders where we would be had we followed the opinion of the Digital Equipment Corp. co-founder, who infamously said in 1977: "There is no reason for any individual to have a computer in his home." That narrow vision did not work for DEC and it would not have worked for the rest of us, had we embraced it.

We are better off today than we were 100 years ago when the average life expectancy in the US was 48 years. Today, it is 78, but we still can't prevent or cure many cancers, nor stop and reverse heart disease. Yet, we can stop most, if not all of the 200,000 plus preventable deaths that occur each year in our hospitals.

This will require an "all-in" commitment, and is the reason I helped found the Patient Safety Movement, a "Network of Creative Cooperation", as President Clinton put it; a collection of caring clinicians, patient advocates, hospitals, innovators and medical technology companies, who came together to eliminate preventable deaths by 2020. We believe there are seven major areas of work ahead of us:

- **Break down the silos and unify the healthcare ecosystem.**
- **Promote transparency.**
- **Create Safety Solutions to the challenges that are causing preventable deaths.**
- **Use incentives and disincentives to reduce preventable deaths**.
- **Eliminate misaligned incentives.**
- **Create the "Patient Data Super Highway".**
- **Promote Love and Patient Dignity**

At the Patient Safety Movement, we believe addressing the challenges and capitalizing on the opportunities will require all members of the health care ecosystem to actively engage in order to eliminate preventable deaths. Congress has a big role to play in this as you consider public policy options to improve patient safety.

Whether you are young or old, Republican or Democrat, black, or white, religious or not, this is an issue that we all can and must gather around to fix, and fix it now. I believe it is our moral imperative to do all that we can now, because the solutions to many, if not all, of the problems that lead to preventable deaths are available today and do not require new science or FDA approval. They just require us to act – individually and collectively. They require us to make a stand so that mediocrity, disconnections, lack of conviction, apathy, and an 'us and them' mentality does not get in the way of what is best for patients.

You have many tools at your disposal, from public health programs that measure and track infections and deaths, to reimbursement systems that create incentives to do the right thing. We stand ready and willing to assist you if you step up and accept the safety challenge.

The Patient Safety Challenges:

Challenges that are causing the preventable deaths, such as hospital acquired infections, failure to rescue, and medication errors, already have solutions that we just need to implement. But, disconnected information and understanding of the patient care pathway and the inability to share information among providers is another problem that is costing us lives and dollars, and it's currently without a solution. The case of 12-year-old Rory Staunton, who died of sepsis at a New York hospital in July 2012, is a sad reminder of how the lack of communication between providers, combined with the lack of interoperability among multiple machines in the hospital can contribute to tragedy.

Only a few days after suffering what appeared to be a minor cut from a fall in his school gym, Rory passed away from a septic infection. The data to save him was there – it just wasn't following him as he visited his providers and wasn't being communicated properly, and so no one connected the dots.

We need patient data in real time so that caregivers can be alerted by predictive algorithms on the status of their patients in real time, not after a preventable death has already occurred.

If we can bring the machines and IT all together with intelligent predictive algorithms, physicians, along with patients and their families can be informed of dangerous trends; lives can be saved; and process of care can be improved substantially, further reducing cost. Currently such algorithms can't be realized however, because there is no easy means to integrate the data streams of the numerous medical devices. The 'Patient Data Super Highway" that is required for this goal doesn't exist. This is because many

companies do not allow other companies to have access to the patient data their products produce or capture.

While technology and processes may be arguably half of the solution, empathy and love for the vulnerable is the other necessary half. The dehumanization of people as soon as they become patients in hospitals contributes to preventable deaths. We walk into hospitals as the brave and free and turn into voiceless hostages of an unsympathetic system. I don't buy the argument that if clinicians became involved emotionally with their patients they may not do as good a job. Empathy has a place in health care — it offers patients and their families' dignity and can go a long way toward reducing stress and getting patients and their families to become participants in the care and safety of themselves or their loved ones. An unsympathetic system contributes to suboptimal care, and it is one of the reasons patients and their families often are eager to sue their caregivers if something goes wrong.

Patient Safety: A Challenge That We Can, and Must Meet

Currently we are losing more than 200,000 of our loved ones each year to preventable hospital deaths. Amanda Abbiehl, Lewis Blackman, Leah Coufal, Emily Jerry, and Rory Staunton, are just 5 of the 200,000 precious lives we lose each year in our hospitals.

Each year in the United States, about 2.5 million people die.[1] Of those 2.5 million, 700,000 die in hospitals.[2] Of the 700,000, experts believe the number of preventable US hospital deaths totaled more than 200,000 last year. That is 3,800 deaths per week or more than 500 every single day. It is like 2 full jumbo jets crashing every day with all aboard dying. These deaths far exceed motor vehicle accidents (43,000), breast cancer (42,000), and AIDS (17,000) related deaths, combined.[3]

These statistics are even more startling when you consider the Institute of Medicine's report *To Err is Human*, which came out nearly 15 years ago, pegged the number at approximately 100,000 preventable hospital deaths annually, at a cost of $29 billion.[4] Now it's 200,000.

If we continue at this rate, by 2020 it is conceivable we would lose more than two million of our loved ones to preventable hospital deaths. To me, this is unacceptable. When you

[1] Murphy SL et al. National vital statistics reports; vol 60 no 4. Hyattsville, MD: National Center for Health Statistics. 2012.
[2] Trends in Inpatient Hospital Deaths: National Hospital Discharge Survey, 2000–2010 . National Hospital Discharge Survey (NHDS) data from 2000 through 2010 . 118: March 2013.
[3] HealthGrades Quality Study: Patient Safety in American Hospitals, HealthGrades, July 2004.
[4] Kohn LT et al. To Err Is Human: Building a Safer Health System. Washington, DC: Institute of Medicine; 1999.

meet a family that has lost a loved one, you realize how even one preventable death is unacceptable, let alone 2 million!

Importantly, the numbers of adverse events caused by infections and other issues is much higher. In 2010, an estimated 1.6 million Medicare patient experienced an adverse event. Medicare's own data showed that 44 percent of these incidents were considered preventable.[5]

Cost impact

I am sure everyone in this room shares our belief that there is no dollar value that can be put on a life lost, but the costs are enormous. Consider the following:

- Some studies report the economic cost of preventable errors at $17 to $50 billion annually. [6][7] Many of these errors result in death.
- The Centers for Disease Control and Prevention reports hospital-acquired infections lead to nearly 100,000 deaths and cost $30 billion each year. CDC estimates about 1.7 million HAIs annually. [8]
- Pressure ulcers and postoperative infection are the two highest volume preventable errors and cost more than $6.5 billion annually, according to researchers.[9]

There are many more examples, where saving patients' lives will also save taxpayers, consumers and premium payers money. Clearly, the opportunity is large and Congress should take steps to save money and lives wherever prevention strategies are available.

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[5] Levinson DR et al. Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, Department of Health and Human Services Office of the Inspector General, November 2010.

[6] Shreve, J, *et al*., *The Economic Measurement of Medical Errors,* sponsored by Society of Actuaries Health Section, prepared by Milliman Inc., Schaumburg, IL (June 2010).

[7] Brennan, TA, *et al*., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results from the Harvard Medical Practice Study I," *New England Journal of Medicine*, 324:370–376 (1991).

[8] *Journal of Medicine*, 324:370–376 (1991). Scott, Douglas R., "The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention," Centers for Disease Control and Prevention, (March 2009) accessed at http://www.cdc.gov/hai/pdfs/hai/scott_costpaper.pdf.

[9] Van den Bos, Jill ; Rustagi, Karan ; Gray, Travis ; et al., "The $17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors," *Health Affairs,* Volume: 30, Issue: 4 APR 2011.

Patient Safety Movement Foundation

We created the *Patient Safety Movement Foundation* to aggressively address this problem with a mission of ZERO preventable deaths by 2020.

We believe we can accomplish this by working together and doing the following:

1. Unify the healthcare ecosystem and secure commitments to action from health care providers and others in the healthcare ecosystem;
2. Identify the challenges that are killing patients to create actionable solutions to the challenges; We call these Patient Safety Solutions;
3. Ask hospitals to implement the Patient Safety Solutions;
4. Promote transparency;
5. Align misaligned incentives;
6. Create and use the Patient Data Super Highway; and
7. Promote love and patient dignity.

The Patient Safety Movement is taking on this challenge and is galvanizing the entire healthcare ecosystem. Part of reason, we experience 200,000+ preventable deaths after all of the work that has been done since the IOM report is that all parties that impact patient safety have not been at the table. While clinicians are responsible for care at hospitals managed by administrators and supported by payers, including the government, they utilize devices and drugs invented by clinicians and companies. All of these entities are committed to patient safety, but rarely have they all worked together to collectively create and implement solutions to reduce preventable deaths. We need to bring everyone together from doctors, nurses, hospital administrators, patients, patient advocates, engineers, government agencies, accreditation agencies, elected officials and medical technology innovators to find actionable solutions to commit and achieve ZERO preventable deaths as soon as possible.

We have many institutions that have already made their commitment and are taking action, including Intermountain Healthcare in Salt Lake City, Sinai Health System in Chicago, Mercy Hospital of Buffalo, Hoag Hospital of Orange County, Medstar in Columbia, MD as well as the American College of Obstetricians and Gynecologists, the Newborn Coalition, and LeahsLegacy. We also have many medical technology companies, including Cercacor, Cerner, Drager, GE Healthcare, Masimo, Sonosite Fuji Film, Smiths Medical, Surgicount and Zoll who have committed to share their data to benefit patients worldwide. Numerous doctors, nurses, executive leaders, and patient

advocates have partnered with the Movement and are committing to do everything they can to push toward ZERO preventable deaths.

- At the *Patient Safety Movement's* first *Patient Safety, Science and Technology Summit*, this past January, we successfully secured the commitment of nine medical technology companies to share their data. We thank them for their commitment to patient safety. These are the first bridges we have built to help connect and construct the Patient Data Super Highway. Former President Clinton has been instrumental and been very supportive of this effort. He not only attended our Summit, but is highlighting our work at this year's Clinton Global Initiative meeting in NY. We developed 6 Patient Safety Solutions to address the pressing problems of failure to rescue, medication errors, transfusion overuse, intravascular catheter-related infections, sub-optimal neonatal oxygen targeting, and failure to detect critical congenital heart disease. Each of these solutions identifies the gap, and highlights the necessary leadership, clinical and technology steps to eliminate these problems.

- We are working with the Joint Commission and seeking their help to encourage implementation of Patient Safety Solutions.

- We are working with CMS to educate and incorporate the Patient Safety Solutions into federal policy. We are very encouraged by the pace that CMS, under the leadership of Dr. Patrick Conway, is working with us on ideas for how we can make our hospitals and surgery centers much safer.

- We are working with elected officials to increase awareness on the magnitude of the preventable death problem in our hospitals and to develop and implement solutions.

All these steps have been taken in just one year. At our next summit in January 2014, we will unveil even more Patient Safety Solutions and steps we plan to take to achieve our zero by 2020 goal. We know our movement is nascent, but we believe it is potent and reflects the readiness and underlying desire *by* the healthcare ecosystem to *put an end to preventable hospital deaths*.

We want to thank you Chairman Harkin and Ranking Member Alexander for holding this hearing today to highlight this issue. We ask that this hearing be the start, not the end, of your efforts to address preventable deaths. We are looking to you to lead and spur changes in government policies to further incent best practices and to achieve our shared goal of zero preventable deaths by 2020.

The Necessary Legislative Response

We know Congress and the administration have been actively focused on this issue of reducing preventable deaths and increasing patient safety with many programs, but we humbly suggest the following:

- **Create a System of Transparency-**Transparency is a critical component in measuring and understanding the total number of preventable hospital deaths and the root cause of each death. This information will allow clinicians, policy makers, and others to take proactive steps to reduce and eliminate needless mortality, going forward. The current reporting systems do not require consistent, accurate, measurable and electronic reporting on the total number and causes of deaths, especially related to whether the death was preventable. We cannot improve what we do not measure. You may be surprised as I am, that today no one knows the exact number of deaths due to preventable causes. That has to change immediately.

- **Recommendations:** Government should take the lead in this effort. To create transparency, and improve consumer choice and knowledge, we believe there should be standardized processes to define, measure and report Hospital Acquired Infections and Conditions by hospital and in total. Reporting should be electronically facilitated through the Meaningful Use program and via claim submissions. Congress should require HAI and HAC rates to be publicly reported to facilitate quality comparisons, much like SEC does for finance.

- **Use incentives and disincentives to reduce preventable deaths**

  Recommendation: We believe Congress should expand the current HAC Medicare policy to include list of causes of preventable death. We believe Congress should suspend payment for even the primary condition until it is determined whether the cause of death was preventable. If preventable, and the hospital has implemented evidence based strategies for prevention, such as those indicated by the Patient Safety Solutions, the hospital would receive payment for the primary condition. If the hospital had not implemented the strategy, then payments for both the primary and secondary conditions would be denied.

  Also, if hospitals implement evidence based practices such as the Patient Safety Solutions, they should be shielded from malpractice lawsuits to the fullest extent possible, such as through an affirmative defense and limits on damages.

  We believe Congress should also expand the current HAC Medicare policy by expanding the non-payment policy for secondary conditions that develop after a patient is admitted to a hospital. The current list of conditions has not been

updated since 2012, partly due to limits on what conditions can be added. Currently, only preventable, high-cost, high-volume conditions for which there are evidence based precautions are eligible. Congress should eliminate the "high-cost, high-volume" limitation so that any known preventable condition is eligible for the list if there is a clinical intervention strategy to prevent it.

- **Create the "Patient Data Super Highway"** For more than a decade Congress and the Administration have devised and implemented policies to spur the use of information technology in healthcare. The reasoning behind this is clear: seamless information technology should enable us to identify problems in real time and resolve them before they become deadly. As a result, medical professionals have begun to increasingly rely on medical technology and information systems to treat their patients. Today, however, these technologies are not always able to communicate or interoperate. But this isn't always an issue of design or standards: some technology vendors—as well as some providers—pursue business practices to create what are called "walled gardens," which are strategies that block information sharing between different systems in order to capture market share and/or additional revenues in the future. This is an issue that has been identified by the Office of the National Coordinator as a barrier to progress in the Meaningful Use program. This practice fundamentally diminishes the value of health IT, undermines Congressional intent in enacting programs to incentivize the use of technology in healthcare. These practices are harming our progress to protect patients and must be stopped; technology solutions must be required to openly share information particularly when their purchase is subsidized with taxpayer dollars and patients' lives are dependent on it. Rory Staunton's case is an example of the problem and opportunity that lies ahead. In fact, according to an article in the Los Angeles Times, 80% of medical errors in hospitals involve communication problems between healthcare professionals.

- **Recommendation:** We believe Congress should grant the Office of the National Coordinator for Health Information Technology (ONC) the authority to investigate and decertify products that pursue information blocking practices. We shouldn't provide incentives or reimbursement for products that do not openly share data freely with not just the hospitals, but under HIPPA, to the patient and all parties that can use it to improve patient safety.

- **Provide the Same incentive to Medical Technology Companies that is offered to Hospitals** Today, there are no incentives, only penalties, for medical technology companies that are trying to do the right thing and identify why a patient was harmed by their product to do so publicly. Hospitals are afforded protections for reporting adverse events through Patient Safety Organizations.

Recommendation: Congress should extend the legal safe harbors afforded to providers through Patient Safety Organizations to technology vendors to promote transparency that will benefit the system overall.

- **Promote Patient Dignity** Too often a patient's or a family's cry for help is ignored. Patients and their families must be partners with healthcare providers through education and engagement strategies that empower both providers and consumers.

  Recommendation: We believe there should be a Patient Advocate at every hospital that patients or their families can access in real time if they experience lack of empathy or problems with communication related to their care.

Conclusion

The good news is that preventing avoidable patient deaths can largely be accomplished with solutions that are available today. But we all need to act now. Every week, we are losing nearly 4,000 of our family members, neighbors and friends to healthcare-associated infections and other forms of preventable deaths. If Congress creates laws that align the incentives of the healthcare ecosystem to encourage innovation, transparency, cooperation, implementation of evidence based best-practices such as Patient Safety Solutions, and the creation of a Patient Data Super Highway, we can reduce, if not completely eliminate, preventable deaths.

We are excited to welcome Congress to the Healthcare Ecosystem and work with Congress on solutions to this problem and together achieve **ZERO Preventable Patient Deaths by 2020.**

Below is a Summary of Patient Safety Programs to Reduce Hospital Acquired Infections and Conditions. These are extremely helpful but are not replacement for what we have suggested above.

CMS

CMS has created a number of programs to improve Patient Safety.

The Innovation Center is engaged in a number of innovative projects and is working to develop new payment and service delivery models to improve patient safety.

The Partnership for Patients and its over 3,700 participating hospitals are focused on making hospital care safer, more reliable, and less costly through the achievement of two goals:

1. **Making Care Safer.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010.
2. **Improving Care Transitions.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010.

CMS partners with AHRQ and CDC to develop an algorithm to identify claims-based markers of HAIs originating at surgical care settings. Programs are generally focused on hospital reporting or consumer-facing tools to make the hospital and provider quality more transparent to patients.

- *Inpatient Prospective Payment System Incentives (IPPS)*
  - Hospitals are encouraged to treat patients efficiently and to avoid infections because they receive a MS-DRG-based payment for an inpatient stay.

- *Hospital Pay-for-Reporting*
  - Gives patients quality of care information to make more informed decisions about their healthcare and encourages hospitals and clinicians to improve the quality of inpatient care.
    - Hospitals that don't report on ten specific conditions are penalized.

- *Hospital Value-Based Purchasing (VBP)*
  - A portion of hospital base operating DRG payment amount will be contingent on actual performance, rather than reporting of measurement data, and must include hospital-associated infection rates.

- *Hospital Readmission Reduction Program*

    - Seven conditions make up almost 30 percent of Medicare spending on readmissions. CMS developed reporting measures for four of the seven.
        - The ACA includes penalties for hospitals that have excess readmissions based on the readmission measures developed by NQF.

- *Physician Quality Reporting System (PQRS)*
    - A set of 74 quality measures.
        - 4 are related to hospital acquired infections.
    - Providers receive incentives for reporting and (starting in 2015) penalties for not reporting.

- *Physician Feedback Program and Value-Based Payment Modifier*
    - A Physician Value -Based Purchasing Program to improve Medicare beneficiary health outcomes and experience.
        - Uses payment incentives and transparency to encourage higher quality, more efficiently provided healthcare services.

- *Shared Savings/Accountable Care Organizations*
    - A coordinated care model for Medicare beneficiaries that is required to report on quality including HAI levels. ACOs with better quality and lower cost of care receive a percentage of the money saved by Medicare.

- *Hospital Compare*
    - Hospital Compare (www.hospitalcompare.hhs.gov) is a website for consumers that provides information on how well hospitals provide care to their patients with certain medical conditions, including care related to the prevention of certain infections.
        - Uses at Hospital Pay-for-Reporting requirements.

- *Physician Compare*
    - Consumer-facing website that compares physicians using PQRS Data

- *Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Facilities and Hospice Program*
    - These facilities are required to report new and worsening pressure ulcers and CAUTI events.

- *Value-Based Purchasing for Skilled Nursing Facilities and Home Health*
    - Quality reporting requirements for the prevalence of pressure ulcers.

- Medicare Advantage
    - Medicare Advantage Private Fee-for-Service and Medicare Savings Account plan must have an ongoing quality improvement program that meets the regulatory requirements.

AHRQ

AHRQ funds research to identify and promote effective HAI prevention approaches as well as to identify gaps in the HAI science that can be filled with additional research.

- *Comprehensive Unit-based Safety Program (CUSP)*
  - An Intensive Care Unit Safety Reporting System developed by the Johns Hopkins Quality and Safety Research Group.
  - Focused on Central line-associated bloodstream infections (CLABSI) and Catheter- associated urinary tract infections (CAUTIs).

- *Surgical Unit-based Safety Program*
  - An adaptation of the CUSP program focused on surgical site infections (SSI) and ventilator-associated pneumonia (VAP).

- *Patient Safety Organizations*
  - Encourages clinicians and health care organizations to voluntarily report and share quality and patient safety information without fear of legal discovery.

CDC

The CDC Prevention Epicenters Program is a network of academic centers with which CDC performs collaborative research on the epidemiology and prevention of HAI.

- Safety and Healthcare Epidemiology Prevention Research Development (SHEPheRD) program
  - Includes academic experts in the field, large healthcare facility networks interested in participating in HAI prevention research, and entities with healthcare information on large patient populations that can be used to measure outcomes and the impact of prevention efforts.
    - Over 2,500 hospitals and insurers covering more than 200 million lives are represented in the SHEPheRD program.

- National Healthcare Safety Network & Emerging Infections Program
  - Epidemiologic research that informs prevention efforts and provides estimates of national HAI burden and trends.

Medicare

Medicare's "never events" policy that refuses payment for clinical mishaps that are so horrific they should never happen is helpful in reducing preventable deaths. Likewise, the current Medicare Hospital Acquired Conditions policy, which refuses payment for conditions in certain limited categories that develop after a hospital admission, is helpful in making hospital clinicians and administrations more aware of the financial consequences of avoidable conditions and errors. Beginning in FY2015, the ACA reduces payments to hospitals that have risk-

adjusted HAC rates in the top quartile of hospitals, but more must be done. Evidence based practices are available to address more conditions than are currently on the HAC list, however no new conditions have been added to the list in two years, despite advances in clinical evidence and technology. The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payments for certain hospital-acquired conditions. CMS has titled the provision “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC & POA).

For discharges occurring on or after October 1, 2008, Inpatient Prospective Payment System (IPPS) hospitals do not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case is paid as though the secondary diagnosis is not present. For instance, if a patient falls out of bed while in a hospital, the consequent broken hip was not present on admission, so the "complication" of "broken hip" would be demoted as a "Falls and trauma" HAC. The hospital would not be compensated for treatment of the injury. The intent of this sort of classification is to force hospitals to prevent such problems in the first place.

Pursuant to the Health Reform Law, beginning in FY 2015, hospitals will face an additional 1% reduction in Medicare inpatient payments if they fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year. The CBO estimates this will reduce Medicare spending by $1.4 billion over the 2015-2019 period. (Established by PPACA § 3008 and 10309.)

The Hospital-Acquired Conditions payment provision applies only to IPPS hospitals. At this time, the following hospitals are ***exempt*** from the HAC payment provision:

- Critical Access Hospitals (CAHs),
- Long-Term Care Hospitals (LTCHs),
- Maryland Waiver Hospitals,
- Cancer Hospitals, Children’s Inpatient Facilities,
- Rural Health Clinics,
- Federally Qualified Health Centers (FQHCs),
- Religious Non-Medical Health Care Institutions,
- Inpatient Psychiatric Hospitals,
- Inpatient Rehabilitation Facilities (IRFs), and
- Veterans Administration/Department of Defense Hospitals.

The law requires that, by October 1, 2007, the Secretary was required to select, in consultation with the Centers for Disease Control and Prevention (CDC), at least two conditions that: (a) Are high cost, high volume, or both; (b) are assigned to a higher paying MS–DRG when present as a secondary diagnosis (that is, conditions under the MS–DRG system that are CCs or MCCs); and (c) could reasonably have been prevented through the application of evidence based guidelines. Section 1886(d)(4)(D) of the Act also specifies that the list of conditions may be revised, again in consultation with CDC, from time to time as long as the list contains at least two conditions.

The current list of HACs is:

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Pressure ulcer stages III and IV
5. Falls and trauma, including:
    a. Fractures
    b. Dislocations
    c. Intracranial injuries
    d. Crushing injuries
    e. Burns
    f. Other injuries
6. Vascular catheter-associated infection
7. Catheter-associated urinary tract infection
8. Manifestations of poor glycemic control, including:
    a. Diabetic ketoacidosis
    b. Nonketotic hyperosmolar coma
    c. Hypoglycemic coma
    d. Secondary diabetes with ketoacidosis
    e. Secondary diabetes with hyperosmolarity

As specified by statute, CMS may revise the list of conditions this *could* include other causes of preventable deaths.