

Medicare claims data provide a perspective on trends in HAC rates

Hospital-acquired conditions (HACs) are reasonably preventable conditions that are not present when patients are admitted to a hospital but that develop during the hospital stay. Because HACs not only are harmful and potentially deadly to patients, but also may increase the cost of care, the Affordable Care Act established the HAC Reduction Program to encourage hospitals to take steps to reduce their incidence. Hospitals may incur financial penalties and undesirable publicity for failure to manage these conditions.

Recent literature has indicated significant improvements in the incidence of HACs (although aggregate measures recently reported by Agency for Healthcare Research and Quality

indicate a leveling off of improvements in HAC incidence).

Hospital performance under the HAC Reduction Program is determined based on the hospital's total HAC score. Among the various types of measures that constitute this score, two important and influential ones are rates of central-line-associated bloodstream infections (CLABSIs) and catheter-associated urinary tract infections (CAUTIs), which are dangerous and costly conditions that hospitals should strive to prevent.

Unfortunately, the measures Center for Medicare & Medicaid Services (CMS) uses for tracking hospital performance in preventing HACs are in

INCIDENCE OF CENTRAL-LINE-ASSOCIATED BLOOD-STREAM INFECTIONS PER 10,000 ICU DAYS

Type of Control	2012	2013	2014
For-Profit	4.406385	3.098839	2.169488
Governmental	5.724628	4.495511	3.810274
Not-for-Profit	6.20746	4.724958	3.617124
Total	5.7978861	4.3804616	3.35970021

INCIDENCE OF CATHETER-ASSOCIATED URINARY TRACT INFECTIONS PER 10,000 ICU DAYS

Type of Control	2012	2013	2014
For Profit	2.654434	2.228954	1.967274
Governmental	4.450755	4.335052	4.373917
Not-for-Profit	4.512052	4.483447	3.821525
Total	4.146535	4.029422	3.533303

the early stages of implementation and use data that generally cannot be obtained by the private sector. Although comparative scores are calculated and publicly reported, the scores are difficult to understand and based on inconsistent reporting periods.

To offer a different perspective, we analyzed Medicare claims data for the three most recent fiscal years and developed HAC rates that can be used to observe changes over time or among hospitals. Although administrative data do not provide a clear picture of the clinical issues associated with HACs, such data can be useful for tracking trends in analysis. The numerators presented in the accompanying exhibits are numbers of patients treated in intensive care units (ICUs) with a HAC diagnosis that was not present on admission. The denominators are total patient days in the ICU (10,000 in these particular instances).

The analysis looked at CLABSI rates for short-term acute care hospitals with ICUs, based on Medicare patients treated in ICU and excluding patients with cancer and patients who are immunosuppressed. The analysis also looked at CAUTI rates for short-term acute care hospitals with ICUs, based on Medicare patients treated in ICU, but in this case with no exclusions.

Both analyses found measureable improvement in the incidence of HACs over the three-year period, as well as variations among hospitals according to the type of ownership, as shown in the exhibits. ■

This analysis was performed by American Hospital Directory, Inc, Louisville, Ky. For more information, contact Paul Shoemaker, FACHE, at shoe@ahd.com.

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