Section 5001(c) of the Deficit Reduction Act of 2005 requires the Secretary of Health and Human Services to identify hospital acquired conditions (HACs) that: (a) are high cost or high volume or both, (b) result in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. The Centers for Medicare and Medicaid Services identified 11 categories of HACs that include hospital acquired pressure ulcers (HAPUs), patient falls during a hospital stay, and catheter associated urinary tract infections (CAUTIs). HACs often result in longer hospital stays and increased health care costs. For example, AHRQ has estimated that on average a CAUTI increases hospitalization costs by $1,000, a fall increases costs by $7,234 and a HAPU increases cost by $17,000.[1]

Although overall rates of HACs are estimated to have decreased by 21% from 2010 to 2015, improvements have plateaued since 2013.[2] In addition, whereas CAUTIs is one of the three HACs with the largest improvement (33% reduction), falls and HAPUs are two of the three HACs with the smallest improvement (15% and 10%, respectively) from 2010 to 2015.[2]

These three HACs – CAUTIs, falls, and HAPUs – are interrelated, nursing-sensitive conditions and interventions to prevent each individual HAC may have potential inter-actions and trade-offs such that an intervention designed to reduce the risk of one HAC (e.g., in-dwelling urinary catheter [IUC] removal to reduce CAUTIs) may increase the risk of others (e.g., falls and/or HAPU through impacts on mobility and skin moisture). As a result, patients at risk for CAUTI, falls, and HAPU are subject to multiple, often conflicting prevention strategies, leaving frontline clinicians with challenging clinical decisions to make to promote overall patient safety. To date, there are no tools that clinicians can use in managing these competing risks in an inpatient setting despite the need for such a tool to improve patient safety and its relevance to health care costs from the perspective of health systems and payers.

This project is an aggregate of three information collection requests to develop a toolkit to meet this need using an iterative participatory toolkit design framework. The data collection activity has the following goals:

1. Engage clinicians and hospital/health system administrators to identify informative and practical ways to communicate information to these users of a tool that takes patient-specific information, calculates predicted values of the likelihood of each HAC based on a clinical decision, and displays these values in a way that communicates competing risks of each HAC; and

2. Pilot test the tool through a series of on-site usability tests of multiple visual display prototypes for two to four patient care delivery scenarios that depict likely outcomes using examples of high risk patients to validate and refine the tool's risk dashboard information and visual designs.

TOTAL ANNUAL BURDEN APPROVED: 2967 Hours Per year
BURDEN USED TO DATE: 43 hours.

BURDEN THIS REQUEST: 36 hours (Information Needs Identification Focus Groups).

FEDERAL COST: The estimated annual cost to the Federal government is $772_____.

IS RACE AND ETHNICITY DATA COLLECTED AS REQUIRED?
_____YES _____ NO _____x_N/A

OBLIGATION TO RESPOND:
___x___ VOLUNTARY
_____ REQUIRED TO OBTAIN OR RETAIN BENEFITS
_____ MANDATORY

HOW WILL THIS SURVEY BE OFFERED?
__ ___ WEB SITE
__ ___ TELEPHONE INTERVIEW
__ ___ MAIL RESPONSE [email]
__x__ IN PERSON INTERVIEW
_____ OTHER: _____

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