

January 26, 2023

The Honorable Robert Valdez, Ph.D.
Director
Agency for Healthcare Research and Quality
5600 Fishers Ln.
Rockville, MD 20857

RE: Request for Information on Creating a National Health Care System Action Alliance to Advance Patient Safety, Dec. 12, 2022.

Dear Dr. Valdez:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Agency for Healthcare Research and Quality's (AHRQ) request for information (RFI) on the establishment of a new National Health Care System Action Alliance to advance patient safety. We commend AHRQ and the Department of Health and Human Services (HHS) for their leadership in focusing national attention on patient safety, a longstanding priority for the AHA and our member hospitals and health systems.

The establishment of the action alliance comes at a pivotal time for the health care field. Hospitals approach their patient safety work heartened by important gains made over the past few decades, but also realistic about the profound challenges facing health care. Prior to the COVID-19 pandemic, hospitals implemented robust changes that lead to tangible improvements in patient safety, including double-digit percentage reductions in healthcare-associated infections (HAIs) and other preventable adverse events. Yet, the aftershocks of the COVID-19 pandemic have left hospitals facing often severe staffing shortages, higher patient acuity and complexity, ongoing and unpredictable supply chain disruptions, and unsustainable rises in costs for drugs, supplies and labor. Data showing increases in some HAIs during the pandemic underscore how these circumstances have challenged hospitals' ability to sustain the patient safety progress that hospitals anticipate and patients and communities deserve.

The AHA believes there is a tremendous opportunity to accelerate progress on patient safety by drawing on both past successes and lessons learned from the COVID-19 pandemic. Indeed, hospitals have never viewed delivering safe care as a one-time



achievement. Rather, they recognize that it requires persistent focus and a relentless process of assessment, measurement, implementation, learning and improvement. In this context, we believe AHRQ's Patient Safety Action Alliance can best support the field in advancing patient safety by:

- Aligning its efforts with other federal agencies to ensure federal efforts to accelerate patient safety complement one another;
- Prioritizing resources on addressing the most preventable adverse safety events;
- Engaging patients and providers along the full care continuum — including hospitals, post-acute care providers, behavioral health providers and clinician offices — to identify and advance opportunities for shared progress; and
- Backing the action alliance with robust logistical support to capture and broadly share important learnings and evidence-based care improvement tools.

Additional details on these recommendations follow.

Alignment of Efforts with Other Federal Agencies

AHRQ has long had a leadership role in advancing patient safety, including serving as the lead agency for bringing together the Quality Interagency Coordination (QuIC) Task Force under President Clinton. We were heartened to see the engagement of other key HHS agencies during the action alliance's November 2022 kick-off event, including the Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). All of these agencies have a vital role in supporting patient safety-related work across the health care field, and we believe their continued involvement in the effort will be vital to its success.

The AHA urges AHRQ to ensure that the action alliance's efforts remain aligned and coordinated with other patient safety related efforts across federal agencies, including those at CMS, CDC and FDA. It is important to note that each of these agencies has funded projects underway focused on important aspects of patient safety. For example, CDC's Division of Healthcare Quality Promotion is implementing Project First Line, which is focused on spreading important infection control-related practices across hospitals. CMS also operates its Network of Quality Improvement and Innovation Contractors (NQIIC), which engages hospitals and other health care providers in time-limited quality and patient safety improvement initiatives. These projects are backed by intensive data reporting processes and technical support. We encourage AHRQ to ensure that its action alliance efforts complement — and not duplicate or contradict — these efforts. For example, if there are tools or practices from Project First Line and the NQIIC work that already are showing results, the Action Alliance could seek to find ways of sharing those results more broadly. This alignment will reduce confusion and emphasize the importance of making improvements in safety in these important areas.

Prioritizing Preventable Adverse Events

Among other questions, AHRQ's RFI asks for feedback on what aspects of patient safety should be prioritized by the action alliance. The AHA believes that the answer to which

specific topics to prioritize is likely to change over time as the data and evidence about the opportunities to improve patient safety continues to emerge. **However, as a general principle, the AHA believes that the most actionable focus for short-term efforts to improve patient safety is preventable adverse events.**

Several studies have attempted to characterize the frequency of adverse events, and make a determination of what proportion are the most preventable. While data sources and methods vary, the general direction of these studies' findings is that the majority of adverse events are not preventable, at least not yet. For example, HHS's Office of the Inspector General published a report last year showing that while 25% of the Medicare patients whose 2018 records were examined were thought to have incurred some adverse event during their patient stay, only 43% of those events were thought to be preventable. Earlier this month, a New England Journal of Medicine study published by a team of patient safety experts suggested a similar proportion of hospitalized patients experiencing an adverse event, with about 23% of the adverse events being potentially preventable.

Preventable adverse events like many health care associated infections and medication errors can be greatly reduced with known and effective strategies, backed by rigorous measurement and ongoing governance and oversight by hospitals. By contrast, for non-preventable adverse events, there is not yet clear evidence showing what combination of practices, safety culture, workforce support or governance and oversight can prevent those events. There remains a great need for fundamental research and innovation to make the "universe" of non-preventable adverse events smaller. But, we believe hospitals and the federal government alike have an obligation to prioritize the prevention of adverse events that we know are potentially preventable.

Engaging Patients and Providers along the Full Continuum of Care

The RFI also asks which stakeholders should be engaged through the action alliance. **We encourage AHRQ to consider mechanisms of bringing the patient voice into the work of the action alliance.** For example, AHRQ could seek to solicit patient perspectives on the topics it identifies as highest priority through focus groups and reactor panels. AHRQ could also identify a cadre of patient groups that hospitals and other providers involved in the effort could invite to working group discussions. Hospitals have repeatedly stressed the helpfulness of patient and family perspectives and observations in helping to inform their quality and patient safety improvement work.

The AHA also believes the pandemic has reinforced the critical importance of advancing safety along the whole continuum of care. **That is why we urge that the action alliance engage the full continuum of health care providers including hospitals, post-acute care providers, behavioral health providers and clinician offices.** Patients move among settings to get the care they need. While the nature of patient safety challenges can look somewhat different in each setting of care, there are multiple areas of mutual interest across provider groups. For example, transitions in care are an opportunity to prevent potential safety issues by ensuring post-acute care providers have the information they need about a patient's condition and treatments. Clinician offices can be better equipped to prevent re-hospitalizations if they have the information they need, and hospitals can make

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the care they deliver better when they can draw on important information about a patient's history collected by their trusted primary care physician.

Logistical Support

The AHA recognizes that AHRQ's action alliance would likely rely on in-kind support from the federal government, rather than direct grant-making to hospitals or other health care providers to advance the support. **While we believe there remains a role for grants to hospitals to support this vitally important work, the action alliance can maximize its impact by offering robust logistical support to capture and broadly share important learnings and evidence-based care improvement tools.**

For example, the action alliance can create a central website that serves as a repository of its work. To the extent that the action alliance convenes meetings of providers that focus on sharing best practices, we encourage it to document those practices and ensure they are posted to the central repository. The action alliance could also ask participants to share example tools and policies that they may be using to advance safety, and organize them in an easily accessible way. Lastly, consistent with our recommendation to coordinate with other federal agencies, the action alliance's website could offer links to resources produced by other federal projects.

The AHA thanks AHRQ for the opportunity to offer our advice and perspectives as the agency establishes the Action Alliance to Advance Patient Safety. We look forward to working with you to help the alliance deliver on the goal we all share — making health care better and safer for all whom we have the privilege of serving. Please contact me if you have questions or feel free to have a member of your team contact Akin Demehin, AHA senior director for quality and patient safety policy, at ademehin@aha.org, or Nancy Foster, AHA vice president for quality and patient safety policy, at nfoster@aha.org.

Sincerely,

/s/

Molly Smith
Group Vice President, Public Policy