Analysis of Current and Potential Nursing Policy Implications of CMS' Decision on Hospital-Acquired Conditions

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Preface

The author completed this report during her enrollment at Washington State University – Vancouver. She entered the Registered Nurse to Bachelor of Science in Nursing program in December 2007 and graduated in December 2008. During her last semester she completed N507 Healthcare Policy Analysis, taught by Louise Kaplan, PhD, ARNP. This report fulfilled the health policy clinical practicum requirement of one credit for the course. The following document analyzes the current and potential nursing policy implications of the Centers for Medicare & Medicaid Services (CMS) decision on hospital-acquired conditions. The report also examines background information and related topics surrounding CMS' rule.

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Introduction

On October 1, 2008, the Centers for Medicare & Medicaid Services (CMS) implemented a relatively new concept in healthcare. It will no longer pay for 10 hospital-acquired conditions. Medicare pays for services based on diagnosis-related groups (DRGs) that allow fixed payments to healthcare providers. For example, a hospital would be paid a set amount for a patient diagnosed and admitted with pneumonia, despite the quality or outcomes of care, or the bottom line cost of care (CMS, 2006). If the patient developed a catheter-associated urinary tract infection, under the prior system, the hospital was allowed to bill Medicare for treatment and care for both the pneumonia and urinary tract infection. Recently, the DRG structure came under scrutiny for its lack of focus on quality healthcare. Under the new rule, hospitals must assume responsibility for the associated costs of certain hospital-acquired conditions.

The regulation holds hospitals and healthcare professionals responsible for the care they provide. The financial burden of medical errors has shifted to hospitals and this burden along with other incentives has encouraged hospitals, administrators, federal and state entities, and public and private organizations to continue focusing on improving the quality of healthcare and increasing patient safety. CMS' decision is an essential step in reforming healthcare and should be viewed as a desirable and positive change in the American healthcare system.

Background Information

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Modernization Act) and the Deficit Reduction Act of 2005 (DRA) prompted a healthcare payment system reform focused on improving the quality of healthcare. The Modernization Act called for a contemporary reform of the Medicare system. Under the Modernization Act, participants are given enhanced benefits,

expanded choices, savings, and prescription drug coverage (White House, 2003). The DRA, signed by President Bush in February 2006, contains federal spending on entitlement programs such as Medicare, Medicaid, and Social Security. Spending on entitlement programs is increasing quicker than the economy or the population and by 2030 the cost of entitlement programs will reach 60% of the federal budget (White House, 2006). The DRA allows certain reform and policy changes aimed at reducing the spending on Medicare, Medicaid, and Social Security.

CMS began working with healthcare entities to develop and identify quality standards that could be used as guidelines for public transparency for reporting and payment of healthcare services. The Hospital Quality Alliance (HQA) formed in December 2002 to serve as the reporting agency for healthcare quality measures. HQA, in collaboration with hospital representatives, consumer advocates, physician and nursing groups, employers and payers, and government agencies, formed a national public-private organization that offers current and important data on hospital performance in an easy to understand manner (HQA, 2008). The Alliance strives to inform the public on specific quality measures and advance quality healthcare. The foundation of HQA is the database collection and reporting system, Hospital Compare, which makes public the performance of hospitals (HQA, 2008).

In 2003, eligible hospitals could report data to HQA on 10 specific quality measures. Eligible hospitals include acute care hospitals, children's hospitals, and critical access hospitals. Beginning in 2004, based on provisions of the Modernization Act, hospitals that participated in the voluntary reporting of valid data would be reimbursed by Medicare at a higher rate than if they did not report the data (CMS, 2006). The DRA expanded the 10 quality measures and as of 2008 the list includes over 26 measures (Hospital Compare, 2008).

The quality measures relate to five conditions: acute myocardial infarction, heart failure, pneumonia, surgical care improvement/surgical infection prevention, and asthma care (children only). Hospitals report data on quality measures rooted in scientific, evidence-based practices. For example, the best practices for patients experiencing acute myocardial infarctions include aspirin and beta blocker upon arrival to emergency room and at discharge (Hospital Compare, 2008). The Hospital Compare website offers detailed explanations regarding all measures.

CMS evolved the concept of linking payment to quality and began several other exhibitions targeting improved quality of care. CMS began a Physician Group Practice Demonstration in 2005 that incorporated 10 large physician groups. The initiative focused on paying providers based on the quality of care received and the quality of the data reported, rather than the DRG service program. Evidence shows that a proactive approach to healthcare that anticipates the needs of patients and is based on prevention, leads to better outcomes, less hospitalization, and decreased expenditure (CMS, 2005). Another exhibition includes the Premier Hospital Quality Incentive Demonstration that results in higher payments to hospitals that perform the best. CMS also began several other initiatives aimed at quality such as the Health Care Quality Demonstration and the Care Management Performance Demonstration. Collectively, these demonstrations were used by CMS to collaborate with Congress on legislation aimed at modifying payments depending on quality and efficiency of care received (CMS, 2006).

The National Quality Forum (NQF) is a membership organization aimed at developing and executing a national plan for healthcare quality measurement and reporting. The non-profit

organization of private and public sector represents a wide variety of healthcare entities including local and national consumer advocate groups, public and private purchasers, employers, health plans, healthcare professionals, labor unions, and organizations devoted to researching and improving healthcare (NQF, 2008).

In 2002, NQF developed a list of 28 serious-reportable events that fall into six categories: surgical, product of device, patient protection, care management, environmental, and criminal. Conditions that fall under these categories include surgery performed on the wrong body part, patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the facility, artificial insemination with the wrong donor sperm or wrong egg, and abduction of a patient of any age (NQF, 2008). A complete list of serious-reportable events can be found at www.qualityforum.org. The goal of the list is to improve consumer access to information and improve accountability of healthcare. The list was developed in collaboration with private and public organizations and federal and state agencies involved in research and quality improvement of healthcare (NQF, 2008).

In 2003, Minnesota enacted the *Adverse Events Reporting Law*, becoming the first state that requires all hospitals, community behavioral health hospitals, and out-patient surgical centers to report on NQFs 28 serious-reportable events (Minnesota Department of Health, 2008). More than 25 states mandate disclosure of serious-reportable events and some states have developed a hybrid list of their own or have adopted list of NQFs 28 events (NQF, 2008).

CMS announced its review of serious-reportable events in 2006, and in conjunction with the NQF and the Centers for Disease Control developed its own list of serious-reportable events. According to CMS, serious-reportable events are "Identifiable, preventable and serious in their consequence for patients, and indicate a real problem in safety and credibility in a healthcare facility (CMS, Press Release, May 2006)." CMS further defines hospital-acquired conditions as conditions believed to be reasonably preventable with the application of evidence-based practices (CMS, 2006). The term, serious-reportable events, is an umbrella term that includes never-events and hospital-acquired conditions. CMS explains that never-events are serious and costly errors that can cause serious injury or death to the patient and should never happen. For the purpose of this paper the terms have been combined together under hospital-acquired conditions.

A major publication by the Institute of Medicine (IOM), entitled, *To Err Is Human, Building a Safer Health System,* reported that a minimum of 44,000 and possibly up to 98,000 individuals die each year from medical errors (IOM, 1999). The report details how healthcare professionals, state and federal agencies, and consumers can reduce the incidence of medical errors. Another report by the IOM, *Crossing the Quality Chasm,* takes a broader approach to healthcare reform and tackles quality improvement and restructuring of the healthcare system (IOM, 2001). *Crossing the Quality Chasm* includes improvement measures aimed at providing high quality care for patients by six goals. The goals center on: safety, effectiveness, patient-focused care, timely and efficient care, and equitable care. The report also describes funding requirements, preparation of healthcare providers, and many other issues concerning quality healthcare (IOM, 2001).

CMS developed eight hospital-acquired conditions that would no longer be paid for on or after October 1, 2008, the beginning of their fiscal year 2009. Those eight conditions were expanded to include two more in the final rule published by CMS. The 10 conditions are (CMS, Hospital-Acquired Conditions, 2008):

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
    - Fractures, dislocations, intracranial injury, crushing injury, burns and electric shock
- Manifestations of poor glycemic control
    - Diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Surgical site infections:
    - Coronary artery bypass (CABG) – mediastinitis
    - Bariatric surgery
        - Laparoscopic gastric bypass
        - Gastroenterostomy
        - Laparoscopic gastric restrictive surgery
    - Orthopedic procedures
        - Spine, neck, shoulder, elbow
- Deep vein thrombosis/pulmonary embolism following:
    - Total knee replacement
    - Hip replacement

Medicare uses a payment system referred to as the Inpatient Prospective Payment System (IPPS). The system organizes the costs incurred by beneficiaries of Medicare Part A, also called hospital insurance, into groups of prospectively set rates (CMS, 2008). Using the IPPS system, hospitals organize conditions into diagnosis-related groups (DRGs). Each DRG has a specific cost associated with a code, which is based on the average cost that Medicare pays for the average patient experiencing that condition (CMS, 2008). The DRG reimbursement system is used by Medicare, most state run Medicaid programs and many private organizations (Knauf et al., 2006).

An adjusted billing and coding system was developed to support CMS' rule. This new system was assigned mandatory application on January 2008 but facilities could adopt the practices on October 2007 (ECRI, 2008). The new coding system executes a process involving present on admission (POA) codes. These codes are associated with the admitting diagnosis and allow the hospital to bill Medicare for the cost incurred to treat the condition and the admitting diagnosis (CMS, 2007). For example, a

patient presents at the emergency department with signs and symptoms of a cerebral event or stroke. Physical exam shows a stage III pressure ulcer on the patient's sacral area. The hospital would bill CMS for the admitting diagnosis of stroke with a POA secondary diagnosis of stage III pressure ulcer. This allows Medicare to determine that the potential hospital-acquired condition was present upon arrival to the emergency department and did not develop during the course of stay.

Prior to the implementation of this rule, CMS paid the additional cost incurred by hospital-acquired events. As of October 1, 2008, under the new rule, CMS no longer pays for the extra cost created by medical errors and associated complications and instead, hospitals will assume the cost. The rule also forbids hospitals from billing patients for the 10 hospital-acquired conditions listed above (Kaiser Foundation, 2007).

Other organizations have followed CMS' lead in pursuit of increasing quality healthcare and denying payment for certain hospital-acquired conditions. WellPoint Inc. insurance company began a program in Virginia that included four events from NQF's list for which they will no longer pay (Furhmans, 2008). Aetna Inc., the nation's third largest insurance company began requiring that contracts with hospitals include not paying for the 28 serious-reportable events on NQF's list (Furhmans, 2008). Certain state run Medicaid programs have adopted regulations similar to CMS'. In June 2008, New York's State run Medicaid program stopped payment for 14 hospital-acquired conditions (New York Department of Health, 2008).

Current and Potential Nursing Policy Implications

During the past decade, healthcare reform has become a major endeavor. Numerous organizations are striving for consistent, evidence-based healthcare, driven by a desire to improve patient safety and quality of care, and contain costs. One aspect of healthcare reform targets reducing medical errors. Evidence shows registered nurses (RNs) play a vital role in reaching that goal. Policy makers are beginning to understand the correlation between RNs and patient outcomes and have developed policies that address safe staffing, patient safety, and reporting of nursing data. There still remains a need for additional nursing policies that will guide healthcare facilities and RNs in the ongoing effort to reform healthcare in the United States.

Mounting evidence continues to link many facets of nursing, such as nursing hours per patient day and skill mix, to patient safety and outcomes (Kurtzman & Jennings, 2008). A systematic review of studies by Needleman, Kurtzman and Kizer (2007) explained that by increasing the proportion of RNs in hospital settings a variety of patient outcomes can be positively impacted. Increasing the education level of RNs to a baccalaureate degree also improves patient outcomes. The results of Linda Aiken's study in 2003 concluded that hospitals with more baccalaureate prepared nurses resulted in decreased patient mortality and failure-to-rescue rates (Aiken et al., 2003). In 1997, the American Nurses Association (ANA) launched a study titled, *Implementing Nursing's Report Card: A Study of RN Staffing, Length of Stay, and Patient Outcomes,* that examined the correlation between nurses and patient outcomes. The purpose of the study, which involved 502 hospitals in three states, was to measure nurse staffing, untoward patient events and length of stay, and to examine if a correlation existed between the variables (ANA, 2008). The results showed that increased numbers of RNs resulted in a

decrease in preventable conditions, specifically pressure ulcers, pneumonia, urinary tract infections, and post-operative infections. Nursing researchers agree that there still remains a strong need to establish more definitive relationships between nursing care and patient outcomes (Savitz, 2005).

Ann Roger's work underscores the ability of registered nurses to reduce medical errors and points out that the ability becomes compromised when RNs work long hours. Rogers et al. (2005) documents the relationship between nurse work hours and patient safety and explains that with every hour after eight hours, RNs have compromised judgment and an increased number of errors. The research also reports that length of shift, overtime, and number of hours worked per week had considerable effects on errors. Her research supports the Institute of Medicine's position on minimizing 12 hour shifts in the hospital and limiting nurse work hours to 12 hours or less in a 24 hour day (Scott et al., 2006).

Over the past decades, cost containment led to downsizing of RN positions, increased nurse-patient ratios and hiring of unlicensed ancillary staff (ANA, 1999). Cost containment also led to decreased length of hospital stay and a system where only the acutely ill are admitted and treated. In other words, RNs now care for an increased number of sicker patients during a compressed hospitalization time. This shift in healthcare prompted RNs to begin voicing their concerns about shortages, compromised quality, burnout, and job dissatisfaction (Savitz, 2005). Numerous studies analyzed how cost containment could affect healthcare workers, care delivery, and patient safety. The results of these studies serve as a foundational base for the increasing need for nursing policy that addresses patient safety and outcomes (Savitz, 2005).

Efforts for quality care began decades ago and in 1994, the ANA began a multi-layered program concentrating on numerous items and among them were patient safety and outcomes. The initiatives by ANA included the study cited above, *Implementing Nursing's Report Card: A Study of RN Staffing, Length of Stay, and Patient Outcomes.* Other initiatives included developing and defining nursing-sensitive quality indicators and creating the National Database of Nursing-Sensitive Quality Indicators (NDNQI). The ANA defines nursing-sensitive quality indicators as a set of measures that reflect nursing care or its outcomes mainly affected by nursing care. The ANA collects and evaluates data regarding nursing-sensitive indicators from participating hospitals in the United States. Nursing-sensitive quality indicators include: mix of nursing staff (i.e. LPNs, RNs and unlicensed staff) and total number of nursing care hours provided to patients per day, defined as productive, direct patient care (NDNQI, 2007). This data is compared to items including incidence of pressure ulcers and falls. Nursing-sensitive quality indicators also cover patient satisfaction regarding pain management, nursing care, and education. Nursing-sensitive quality indicators reflect nursing structure, process, and outcomes indicators (NDNQI, 2007).

Other healthcare organizations, such as the Agency for Healthcare Research and Quality (AHRQ) and the National Quality Forum (NQF), also identified nursing-sensitive quality indicators (Savitz, 2005). Inconsistencies have developed between organizations regarding definitions and standards of measuring nursing-sensitive quality indicators, which creates difficulties when analyzing data (Savitz, 2005). Collecting data on nursing-sensitive quality indicators serves as one way to track nursing care. Data collection regarding nursing care is paramount as substantial evidence is needed to support the

belief that nurses contribute to cost containment by reducing complications and improving the quality of care experienced by patients in the hospital.

Hospitals typically collect data on specific measures. The ANA's initiatives strive to make this data public and to increase the number of reporting agencies. Reporting of nursing-sensitive quality indicators in Washington State is encouraged but not mandated (Wagner, 2008). A proposed policy would be one that requires every hospital to report nursing-sensitive quality indicators. Over 1,300 hospitals currently report data to the NDNQI (ANA, 2007).

The ANA continues to reform healthcare by striving for the advancement of the nursing profession. In its 2007 Annual Report, the ANA analyze the current, core issues in nursing that include the nursing shortage, appropriate staffing, workplace rights, workplace health and safety, and patient safety and advocacy (ANA, 2007). The annual report summarizes the many activities performed by the American Nurses Association to advance professional nursing. Several areas are addressed and include ethics and standards, professional development, research, and policy. The ANA continues to support and purse partnerships with the Hospital Quality Alliance, the National Quality Forum, and the Agency for Healthcare Research and Quality.

The ANA also supports federal legislation on safe staffing laws and is working in conjunction with the House of Representatives on the *Registered Nurse Safe Staffing Act* (HR 4138). The bill addresses the need for safe RN-to-patient ratios but the ANAs position is that legislation should not set that the number and instead the ratio should be set by the specific units and RNs on that unit. The bill, introduced in 2007, aims to require minimum nurse staffing ratios in Medicare participating hospitals (Library of Congress, 2007). It would require hospitals to develop and implement a staffing plan that guarantees the appropriate number of RNs per shift and per unit to deliver patient care. The bill also outlines public reporting of staffing levels, record keeping of nursing staffing plan, monetary penalties for violations of bill, and whistle blower protection (Library of Congress, 2007).

Five states have developed laws mandating that hospitals create a safe staffing plan that includes unit specific requirements and a committee that is made up of at least 50% registered nurses. These states include Washington, Oregon, Ohio, Illinois, and Connecticut (ANA, Safe Staffing, 2008). Washington State passed House Bill 3123 that requires hospitals to form a safe nurse staffing committee beginning September 1, 2008. The focus of the bill aims to improve patient safety by using evidence-based research on nurse staffing levels in hospitals. The bill requires that at least one half of the members on the committees be registered nurses that deliver direct patient care and the other half designated by hospital administration. The committees establish safe nurse staffing levels based on several items including patient census, level of acuity, staff mix, and level of experience (Washington State Legislature, 2007).

CMS' decision to deny payment for certain hospital-acquired conditions will impact hospital nurses more than any other healthcare professional. The new rule creates the opportunity for nursing policy development by federal and state legislatures, and by hospitals. Hospitals may develop their own in-house procedures to deal with situations arising from CMS' new rule. For example, a hospital may develop a policy describing the procedure to take when a RN finds a present on admission (POA) condition during his or her nursing admission assessment that was not documented by the admitting

physician. According to CMS' rule, POA conditions must be documented by the admitting physician or a provider deemed qualified by licensure. The rule defines provider as a physician or any healthcare practitioner legally able to diagnosis patients (CMS, 2007). A proposed policy would have the RN document the POA condition found during the nursing assessment. Then the RN would notify the admitting physician and a subsequent physician examination of the patient would occur. The physician would document the POA condition by adding an addendum to the original medical exam. The policy would address the need for a timely subsequent examination by the physician.

Other policies that hospitals may develop include education, analysis, and prevention of hospital-acquired conditions. Employees, potentially involved in preventing hospital-acquired conditions, need adequate education regarding hospital-acquired conditions and how to prevent them from occurring. Hospital leadership could establish a quality improvement process that analyzes contributing factors to the occurrence of hospital-acquired conditions. Once contributing factors are identified then proper education can take place and a process that targets prevention could be developed. The value of Registered Nurses cannot be overstated. RNs increase the quality and safety of healthcare that millions of Americans receive in the hospital setting each year, therefore, it is paramount that hospital executives include nursing executives or nursing leadership in quality planning and review. Nursing leadership can ensure accurate and relevant input of data and examine outcomes and impacts of nursing policy changes.

Federal and state legislatures have the opportunity to make major nursing policy changes due to CMS' new rule. CMS' rule created a spotlight on nursing care and the ability of nurses to prevent specific complications in the hospital. A significant and meaningful change in nursing policy would be no longer including nursing care in the room-and-board charges but instead calculating nursing care charges separately. Many nursing researchers have analyzed this concept and postulate the added benefits of separating the two. A study conducted by Laport et al. (2008) analyzed the literature and surveyed international experts on the subject. The study found that it is essential to take into account the variability of nursing care received by patients within the same DRG and further explains that this is not related to a cost accounting measure but more importantly from a management perspective in being able to accurately allocate resources. Welton (2006) argues that nursing care is hidden in policy and payment structures of the healthcare system. He describes this as a major defect because nursing care is included with daily routine and intensive care charges and billed per-diem with room-and-board. Welton (2006) explains that by changing the IPPS system, data will become evident regarding actual nursing care hours spent per patient.

The current IPPS billing system allocates patient care expenses to a specific cost center (CMS, 2008). For example, medications fall under the pharmacy cost center and electrolyte panels to the lab cost center. Nursing costs are compiled into a fixed, standardized cost that fall under two descriptions, routine/floor or intensive care (Welton, 2006). This system does not take into account the varying differences in nursing care that each patient receives. Hospitals are reimbursed by the DRG calculation and imbedded in the weight system is the standard cost for nursing either in routine or intensive room-and-board charges. This implies that all patients on either a routine or intensive floor receive the same amount of nursing care (Welton, 2008).

New policies are needed that change how nursing costs are identified and billed. A new policy could reorganize billing structures into a more accurate format that shows nursing intensity. Nursing intensity refers to the nursing resources or the nurses' work regarding patient requirements. Nursing care hours are also known as nursing intensity. The number of nursing care hours or intensity varies depending on patient acuity, RN-patient ratio, ancillary staff support and other factors. Patient acuity refers to nursing care requirements of the patient and typically is assigned a numerical value. Charges for inpatient hospital care based on the actual nursing care hours would better correspond to nursing expenses and would demand more sophisticated workload analyses and outcomes. This proposed policy would change nursing care charges from a fixed amount to a variable amount, creating a more precise system (Welton, 2008). Studies show patient outcomes are linked to nursing care (Kurtzman & Jennings, 2008), therefore, healthcare accounting practices should begin incorporating nursing care hours into the billing system.

The State of New York began the first healthcare accounting system that incorporates the variability of nursing care into the billing system (Knauf et al., 2006). Twenty years ago, the New York State Nurses Association implemented a process that attaches a nursing intensity weight (NIW) to DRGs. The NIW accounts for the relative value that reflects the quantity and types of nursing resources given to patients based on each DRG. Knauf et al. (2006) reports on the documented correlation between the accuracy of NIWs and hospitals' nursing costs per day.

CMS' new rule on hospital-acquired conditions is one of many changes occurring with the Inpatient Prospective Payment System. In April 2006, CMS announced its proposed changes to the DRG calculations, formulas and payments, and other changes, which are the first changes to the IPPS since the beginning of DRGs in 1983 (Welton, 2006). DRGs were created with the goal of containing excessive charges from hospitals. During this time, nursing care was combined into a scheduled, fixed and constant charge, leaving the acuity of the patient determined by ancillary and diagnostic testing including labs, medications, and radiology (Welton, 2006). This system, however, fails to recognize that nursing care represents the bulk of care received in the hospital setting, not ancillary services (Welton, 2006).

Future Considerations

CMS, in conjunction with the Centers for Disease Control, used a detailed process for selection of its 10 hospital-acquired conditions. The evaluation period included analyzing the cost and volume of conditions, the availability of evidence-based guidelines, determination that the condition was reasonably preventable, and a public comment period (Federal Register, 2008). Numerous conditions were not selected for admittance to the list but may be re-evaluated in the upcoming selection process. These conditions include delirium, ventilator-associated pneumonia, staphylococcus aureus septicemia, clostridium difficile-associated disease, Legionnaires' disease, iatrogenic pneumothorax, and methicillin-resistant staphylococcus aureus. A full description of CMS' decision surrounding these conditions can be found on the Federal Register, Part II, August 19, 2008, beginning on page 39.

Conclusion

CMS' decision to deny payment for certain medical errors beginning on October 1, 2008 benefits consumers, hospitals, and healthcare providers. The rule is necessary to help reduce medical errors and hold hospitals and healthcare professionals accountable for the care they provide. The ongoing healthcare reform now has quality healthcare as the central focus not only of hospitals, providers, and payers but also consumers. The ability of RNs to improve quality care is becoming increasingly evident and CMS' rule gives RNs the opportunity to showcase the importance of their role in the hospital. Hospitals and other organizations have recognized the value of RNs but a wide range of policy development and change are needed. One could consider CMS' rule a nursing policy rule because, intentionally or not, the link between payment and nursing care has been established by the decision.

Prior to the implementation of the rule, hospitals were allowed to bill for errors and hospital-acquired conditions occurring during hospital stays. CMS' decision is an appropriate rule because Medicare, other insurance companies, and consumers should not pay for medical errors. The financial burden now lies with hospitals and the pressure exists to improve the quality of healthcare, educate healthcare professionals, and prevent hospital-acquired conditions from ever occurring.

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