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PATIENT SAFETY ACT

HHS Is in the Process of Implementing the Act, So Its Effectiveness Cannot Yet Be Evaluated

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Highlights

Highlights of GAO-10-281, a report to congressional committees

Why GAO Did This Study

The Institute of Medicine (IOM) estimated in 1999 that preventable medical errors cause as many as 98,000 deaths a year among hospital patients in the United States. Congress passed the Patient Safety and Quality Improvement Act of 2005 (the Patient Safety Act) to encourage health care providers to voluntarily report information on medical errors and other events—patient safety data—for analysis and to facilitate the development of improvements in patient safety using these data. The Patient Safety Act directed GAO to report on the law's effectiveness.

This report describes progress by the Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ) to implement the Patient Safety Act by (1) creating a list of Patient Safety Organizations (PSO) so that these entities are authorized under the Patient Safety Act to collect patient safety data from health care providers to develop improvements in patient safety, and (2) implementing the network of patient safety databases (NPSD) to collect and aggregate patient safety data. These actions are important to complete before the law's effectiveness can be evaluated. To do its work, GAO interviewed AHRQ officials and their contractors. GAO also conducted structured interviews with officials from a randomly selected sample of PSOs.

View GAO-10-281 or key components.
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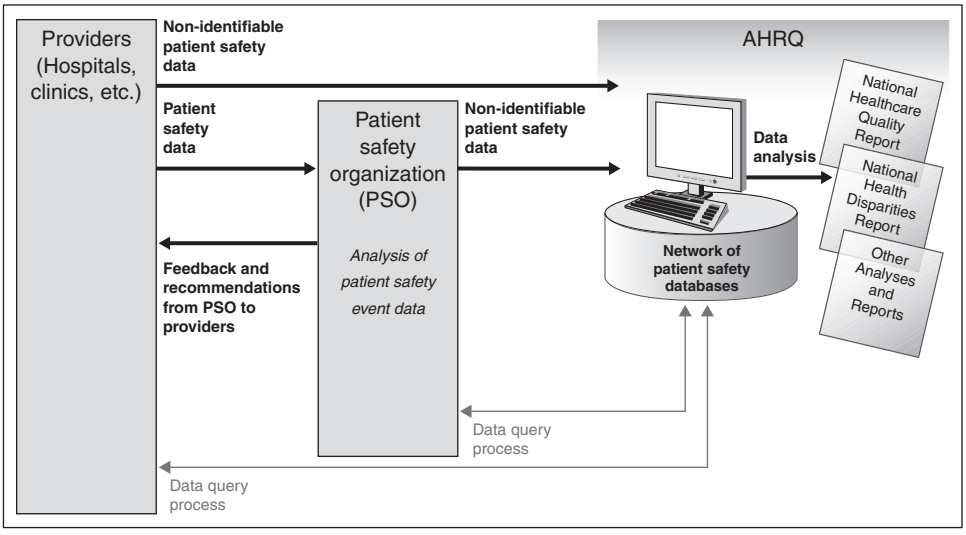
What GAO Found

AHRQ has made progress listing 65 PSOs as of July 2009. However, at the time of GAO's review, few of the 17 PSOs randomly selected for interviews had entered into contracts to work with providers or had begun to receive patient safety data. PSO officials told GAO that some PSOs were still establishing aspects of their operations; some were waiting for AHRQ to finalize a standardized way for PSOs to collect data from providers; and some PSOs were still engaged in educating providers about the confidentiality protections offered by the Patient Safety Act.

AHRQ is in the process of developing the NPSD and its associated components—(1) the common formats PSOs and providers will be required to use when submitting patient safety data to the NPSD and (2) a method for making patient safety data non-identifiable, or removing all information which could be used to identify a patient, provider, or reporter of patient safety information. If each of these components is completed on schedule, AHRQ officials expect that the NPSD could begin receiving patient safety data from hospitals by February 2011. AHRQ officials could not provide a time frame for when they expect the NPSD to be able to receive patient safety data from other providers. AHRQ also has preliminary plans for how to allow the NPSD to serve as an interactive resource for providers and PSOs and for how AHRQ will analyze NPSD data to help meet certain reporting requirements established by the Patient Safety Act. According to AHRQ officials, plans for more detailed analyses that could be useful for identifying strategies to reduce medical errors will be developed once the NPSD begins to receive data.

Intended Flow of Information to and from the NPSD



Source: GAO analysis of AHRQ documents.

The Department of Health and Human Services provided technical comments on a draft of this report, which we have incorporated as appropriate.